

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**0 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**0 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**Dr. John Kehoe:** Medical examiner notified & approved

Dr. John Kehoe, Medical examiner notified & approved

## **CERTIFICATE OF DEATH**

15771

1. PLACE OF DEATH o. COUNTY <b>Pro Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Pro Georges</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Carrollton Md.</b>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Carrollton, Md.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8318 Nicholson st</b>		d. STREET ADDRESS <b>8318 Nicholson st</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>BESSIE</b>	First <b>H.</b>	Middle <b>ALLEN</b>	Last			
4. DATE OF DEATH <b>Nov. 14, 1967</b>	Month	Day	Year			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug 12, 1882</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William Jerome Beron</b>	14. MOTHER'S MAIDEN NAME <b>Amelia Tschsaelli</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <b>Amelia Morton New Carrollton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<b>CARDIAC-RESPIRATORY FAILURE</b>			INTERVAL BETWEEN ONSET AND DEATH	
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO (b)	<b>ACUTE PULMONARY EDEMA</b>		10 DAYS	
		DUE TO (c)	<b>SEVERE ARTERIOSCLEROTIC HEART DISEASE</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> , 19 <b>67</b> , to <b>11/14</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/11</b> 19 <b>67</b> , and that death occurred at <b>4 p.m.</b> from causes and on the date stated above						
22a. SIGNATURE <b>Max M. Herzberg</b>		M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <b>Nov 14, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>MAX M. HERZBERG</b>		22d. ADDRESS <b>3308 Lodge Park Rd Landover, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Congressional Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**M**

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**CERTIFICATE OF DEATH**

15772

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN lb <b>1yr., 1½ mos.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. STREET ADDRESS <b>1850 Potomac Ave., S. E.</b>	
3. NAME OF DECEASED (Type or print) <b>First Augustus</b>		4. DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/15/1889</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>? retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>S. C. (Sumter)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hardy Anderson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jennings</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> years (c) <b>Generalized arteriosclerosis</b> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cor pulmonale due to pulmonary emphysema and bronchial asthma</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/23/66</b> , to <b>11/7/67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/7/1967</b> , and that death occurred at <b>7:40 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11/7/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>11-13-67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>HARMONY MEMORIAL CEMETERY</b>
23d. LOCATION (City or Town) <b>PRINCE GEORGE'S, MARYLAND</b>			
24. FUNERAL DIRECTOR <i>John T. Rhemesco 301-12-476</i>		ADDRESS	25a. RECD BY REGISTRAR <b>NOV 13 1967</b>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Pro Geo					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 6819 Ingraham st					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First John	Middle Allan	Last Anderson				
4. DATE OF DEATH Nov 28, 1967	Month	Doy	Year				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1914	9. AGE (In years 53 last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Dofs Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public relations		10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Allan Anderson			14. MOTHER'S MAIDEN NAME Hilda Hepz				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	16. SOCIAL SECURITY NO.		17. INFORMANT Evelyn W Anderson Cheverly, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				Lerebral Accident ARTerio Sclerotic Heart Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-6, 1967, to 11-28, 1967, that (I) (we) last saw the deceased alive on 11-27, 1967, and that death occurred at 7:55A M, from causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 11/27/67			
22c. PHYSICIAN'S NAME (Type) Robert D. Deitz, M.D.				22d. ADDRESS Prince George's Plaza			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 1, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.		
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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get report from local office

get new information from local office

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*Notify Gasch when service is over.*  
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*when service is over.*  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #8 Film #395 11/29/67 pn Item 23b, telephone call - Gasch's Sons, H. 12/21/67 cad 15774											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN lb <b>4 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellsville</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>						d. STREET ADDRESS <b>Enterprise Road</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <b>Lloyd</b>	Middle <b>E</b>	Last <b>Anderson</b>	4. DATE OF DEATH Month <b>Nov.</b> 22 19 67	Month <b>Nov.</b>	Doy <b>22</b>	Year <b>19 67</b>			
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Oct. 1909</b>	9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W S S D</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>							
13. FATHER'S NAME <b>Albert Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Mae Moffett</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. <b>579 16 4554</b>		17. INFORMANT Address <b>Helen D. Anderson Mitchellville, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Undetermined</b> 7955 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 18, 1967</b> , to <b>Nov. 22, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 22, 1967</b> , and that death occurred at <b>6:00 AM</b> from causes and on the date stated above.								22b. DATE SIGNED <b>Nov 22-1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS <b>Prince Georges General Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 18, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>					
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					
VR A15 (4) 25M 1/67				DATE <b>NOV 27 1967</b>							

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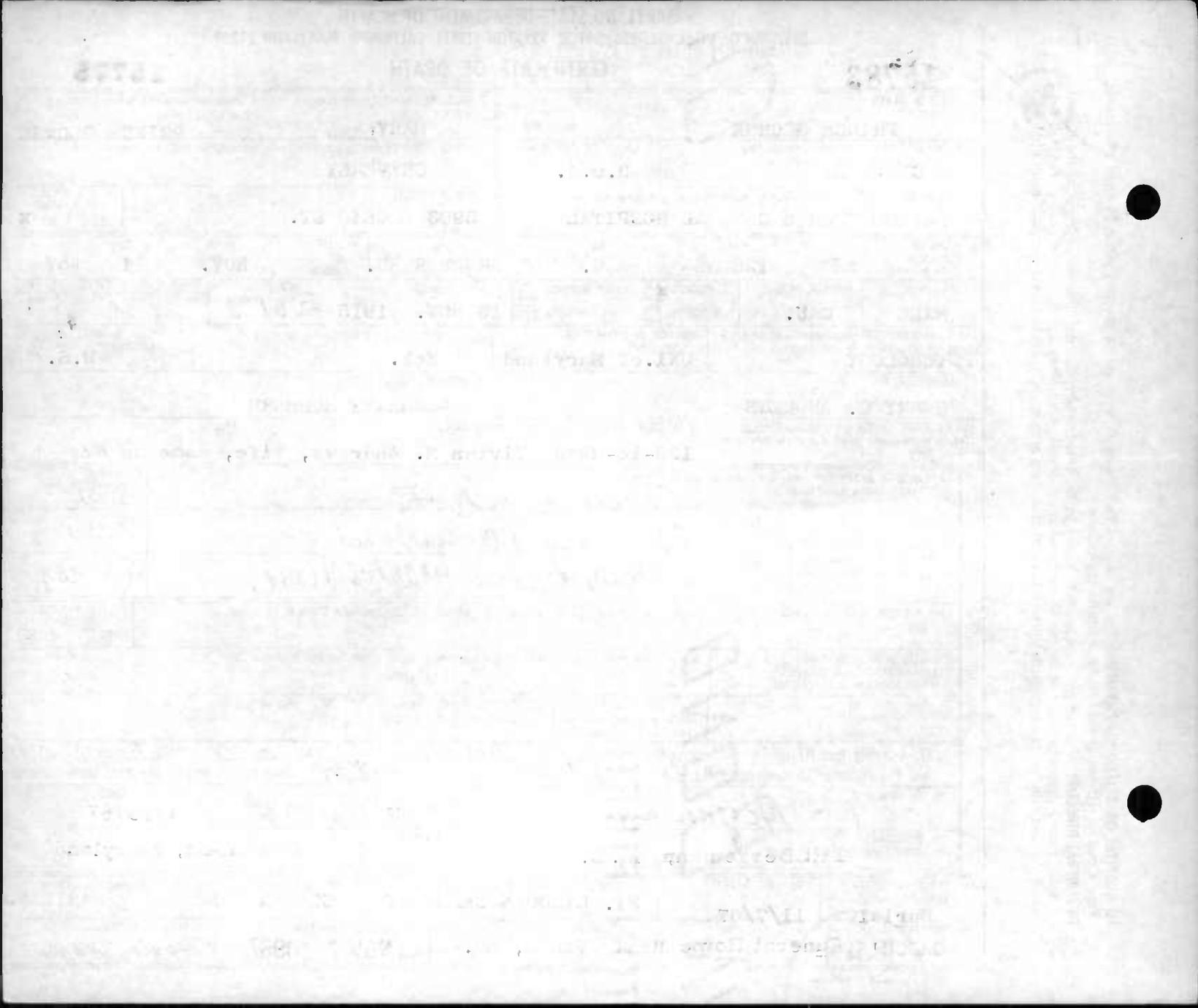
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15783

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>PRINCE GEORGE</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>		d. STREET ADDRESS <b>5903 EUCLID ST.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGE GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>THOMAS G. ANDREWS SR.</b>		First	Middle	Lost	4. DATE OF DEATH <b>NOV. 4 1967</b>	Month	Day	Year
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>16 NOV. 1915</b>	9. AGE (In years last birthday) <b>51 32 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PSYCHOLOGY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNI. of Maryland</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Neb.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A</b>		
13. FATHER'S NAME <b>HENRY C. ANDREWS</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET HUBBARD</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>126-14-2986</b>		17. INFORMANT <b>Vivian N. Andrews, Wife, same as #2</b>		Address		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Coronary thrombosis</b> <b>12 hr</b> DUE TO <b>arteriosclerotic heart disease</b> <b>1 hrs</b> DUE TO <b>5 years</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 18, 1967</b> , to <b>Nov. 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 7, 1967</b> , and that death occurred at <b>8:30 PM</b> , from causes and on the date stated above.								
22a. SIGNATURE <i>Till Bergemann</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/5/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>Till Bergemann, M. D.</b>		22d. ADDRESS <b>Greenbelt, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/7/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>COLMAR MANOR MARYLAND</b>		
24. FUNERAL DIRECTOR <b>GASCH'S Funeral Home</b>		ADDRESS <b>HYATTSVILLE, MD.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>NOV 7 1967</b>		
VR A15 (4) 25M 1/67								



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

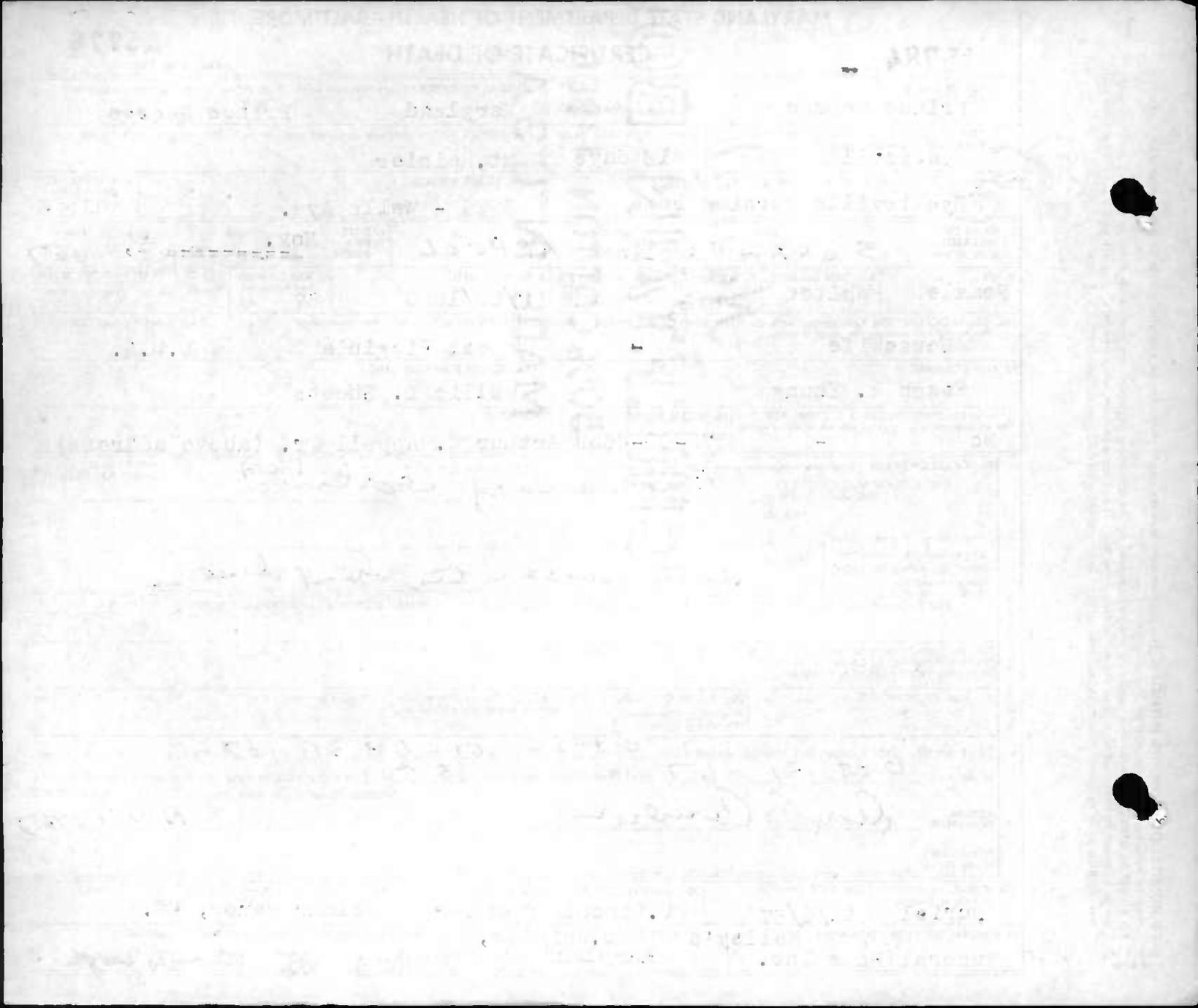
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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hyattsville Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SARAH Adeline APPELL</b>		4. DATE OF DEATH NOV 20 1967	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/20/1880</b>	
9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
13. FATHER'S NAME <b>Mason E. Young</b>		14. MOTHER'S MAIDEN NAME <b>Mollie D. Sheets</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-09-6659</b>	
		INFORMANT <b>Arthur W. Appell Jr. (above address)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema (Son)</b>		INTERVAL BETWEEN ONSET AND DEATH	
4200 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c) <b>arteriosclerotic heart disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Colmar Manor, Md.</b> (County) <b>Colmar</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Oct 28, 1967</b> , to <b>Oct 31, 1967</b> , and that I last saw the deceased alive on <b>Oct 31, 1967</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Colmar Manor, Md.</b>	
ACTUAL SIGNATURE <b>Don B Cameron</b>		DATE SIGNED <b>Nov. 1, 1967</b>	
PHYSICIAN'S NAME (Type) <b></b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/4/67</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home Inc.</b>		24a. REC'D BY REGISTRAR <b>NOV 6 1967</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15785

CERTIFICATE OF DEATH

17414

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>4-1/2 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		d. STREET ADDRESS <b>Rt. 301, Box 4775</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Lewis</b>	Middle <b>G.</b>	Lost	4. DATE OF DEATH <b>November 24, 1967</b>	Month	Doy	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/2/1894</b>	9. AGE (In years lost birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Henry Parsons Armstrong</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Anderson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>8401 Wexford Rd., Marlton, Md.</b> <b>Mrs. Mary Armstrong Gatton-</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Hemorrhagic Pancreatitis</b> DUE TO <b>Biliary Obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(Calculus in ampulla of Vater)</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>LANHAM</b> (County) <b>MARYLAND</b> (State) <b>20801</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 24, 1967</b> , to <b>Nov. 24, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 24, 1967</b> , and that death occurred at <b>11:00PM</b> from causes and on the date stated above.								
22a. SIGNATURE <b>Olivier B. Bond</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-25-67</b>
22c. PHYSICIAN'S NAME (Type) <b>OLIVER B. BOND</b>		22d. ADDRESS <b>6872 RIVERDALE ROAD LANHAM MARYLAND 20801</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/29/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Epiphany Cemetery Upper</b>		23d. LOCATION (City or Town) (County) (State) <b>Forestville, Maryland</b>		
24. FUNERAL DIRECTOR <b>Ritchie Brothers Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
VR A15 25M 1/67								

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#### **Second author**

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												15777	
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>						b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>			c. LENGTH OF STAY IN 1b <b>18 DAYS</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OXON HILL MD.</b>			d. STREET ADDRESS <b>7210 OXON HILL RD</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MALCOLM GROW USAF HOSPITAL</b>												25	
3. NAME OF DECEASED (Type or print)		First <b>ROSE</b>	Middle <b>M</b>	Lost <b>BAKER</b>	4. DATE OF DEATH Month <b>NOVEMBER</b>	Month <b>11</b>	Doy <b>19</b>	Year <b>67</b>					
5. SEX <b>FEMALE</b>		6. COLOR DR RACE <b>CAU</b>	7. MARRIED <b>WIDDWED X</b>	NEVER MARRIED <b>DIVDRCD</b>	B. DATE OF BIRTH <b>9 SEPT 1894</b>	9. AGE (In years last birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS. Days <b>0</b>		Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>CASTLEWOOD VA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>NELSON (NM) MOORE</b>						14. MOTHER'S MAIDEN NAME <b>CYNTHIA E NYE</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>RALPH B NICHOLS</b>				Address <b>7210 OXON HILL RD. OXON HIL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>RESPIRATORY ARREST</b>												INTERVAL BETWEEN ONSET AND DEATH	
7950 IMMEDIATE CAUSE (a) DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>24 October 1967</b> , to <b>11 November 1967</b> , that (I) (we) last saw the deceased alive on <b>11 November 1967</b> , and that death occurred at <b>0525 M</b> , from causes and on the date stated above.													
22a. SIGNATURE <b>Leonard R. Farber</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTDR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11 Nov 67</b>							
22c. PHYSICIAN'S NAME (Type) <b>LEONARD R. FARBER CAPT USAF MC</b>				22d. ADDRESS <b>Andrews B Andrews B Malcolm Grow USAF Hospital Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/13/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Baker Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State)		Russell Co., Va.					
24. FUNERAL DIRECTOR <b>Walter J. Holt</b>		ADDRESS <b>Cunningham Funeral Home Inc. Alexandria, Va.</b>		25a. REC'D BY REGISTRAR <b>Nov 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15787

**CERTIFICATE OF DEATH**

15778

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>		d. STREET ADDRESS <b>4800 Hollywood Rd.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Francis P. Baldwin</b>		First <b>F</b> .	Middle <b>M</b> .
4. DATE OF DEATH <b>11-13-67</b>	Month <b>11</b>	Day <b>13</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-30-03</b>
9. AGE (In years lost birthday) <b>63 yrs.</b>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock Clerk</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Francis P. Baldwin</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Pickett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Spouse &amp; Medical Records</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mycocardial Infarction</b> INTERVAL BETWEEN ONSET AND DEATH 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Coronary occlusion</b> DUE TO (c) <b>Atherosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Baltimore</b> (County) <b>Baltimore</b> (State) <b>Md.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>11-11</b> , 19 <b>67</b> , to <b>11-13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-13</b> 19 <b>67</b> , and that death occurred at <b>10:45</b> A.M., from causes and on the date stated above.			
22o. SIGNATURE <b>D. R. Purdie</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Donald R. Purdie</b>		22d. ADDRESS	
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-16-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Savage Cemetery</b>
24. FUNERAL DIRECTOR <b>Be Witt Donaldson Leland, Md.</b>		ADDRESS	25a. LOCATION (City or Town) <b>Savage, Maryland</b> (County) <b>Howard Co.</b> (State) <b>Md.</b>
			25b. REC'D BY REGISTRAR <b>NOV 16 1967</b>
			25c. REGISTRAR'S SIGNATURE <b>Judge</b>

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office and 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO DEPUTY MEDICAL EXAMINER:** If necessary, please execute the certificate of death and file it with the funeral director. Page 4 should be retained for your files.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

## **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15779

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>5 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		d. STREET ADDRESS <b>Box 274</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Robert</b>	Middle <b>Wesley</b>	Lost <b>Barkley</b>	4. DATE OF DEATH <b>11</b>	Month <b>11</b>	Doy <b>2</b>	Year <b>1967</b>	
S. SEX <b>M</b>	6. COLOR OR RACE <b>WC</b>	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 July 1911</b>	9. AGE (In years last birthday) <b>56 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	Days <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Somerset Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Howard Barkley</b>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Helen Barkley Same</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerotic heart disease</b>				INTERVAL BETWEEN ONSET AND DEATH Minutes <b>unknown</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus 5 yrs</b> <b>Inactive tuberculosis-3 yrs.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John Kehoe</b> EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale M.D.</b>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Baltimore</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-6-67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt Olivet Cemetery</b>		23d. LOCATION (City or Town) <b>Baltimore</b>		(County) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Eugene Wilson 1000 Brantley Ave</b>		ADDRESS <b>Elmwood Wilson 1000 Brantley Ave</b>		25a. REC'D BY REGISTRAR <b>NOV 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		(State)	

877-21

CONFIDENTIAL - SECURITY INFORMATION

877-21

bottom cover

b1

TOP SECRET

PILOTS

WING

WING

ATC 1000

ATC 1000

50 0

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VALVE

VALVE

DE 1000 VALVE 80

DE 1000 VALVE 80

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

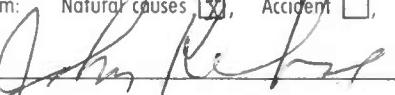
1 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.A. Page 5 may be retained for your files.

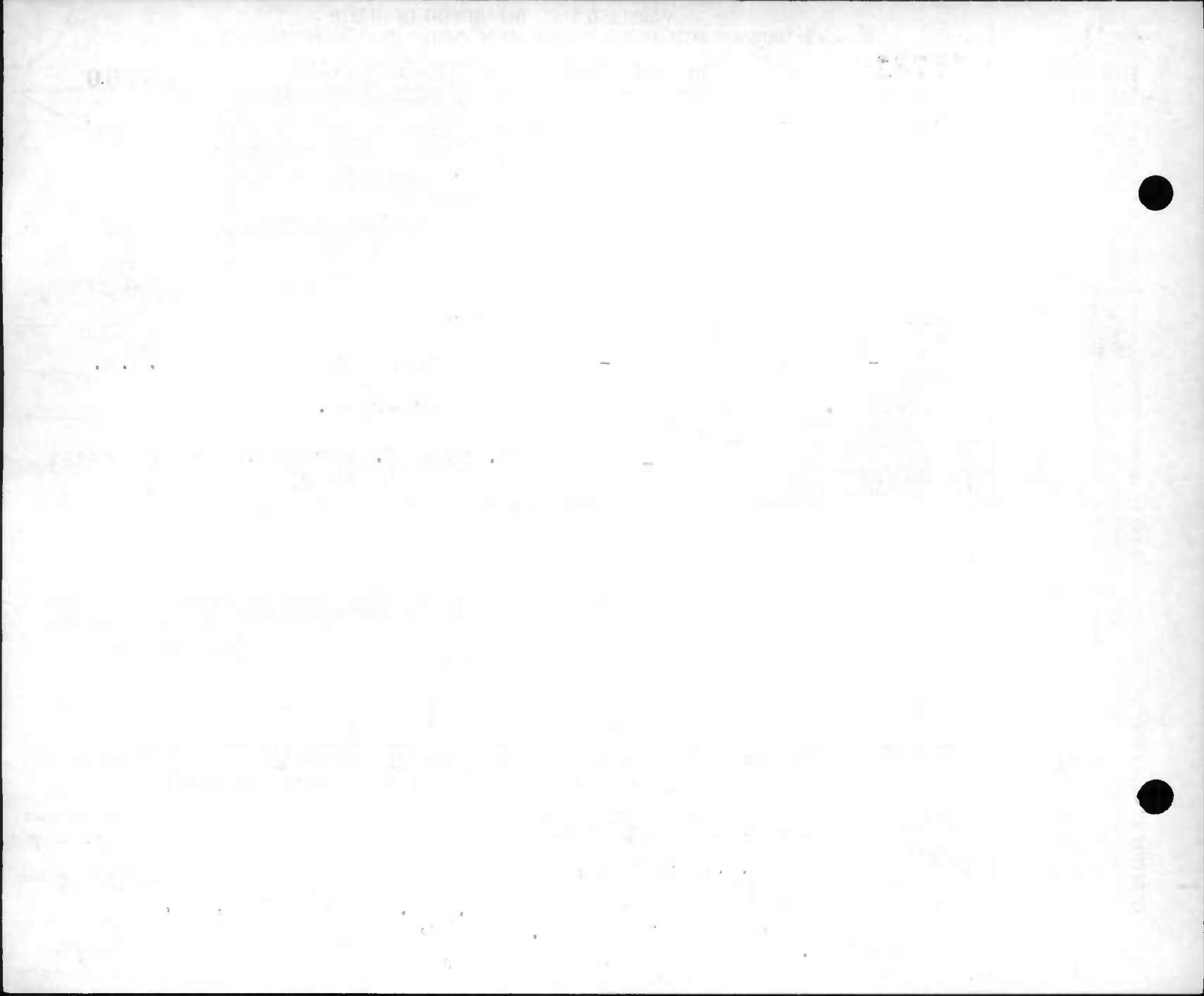
2 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

15789

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15780

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>5024 55th Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Paul Douglas Barnes</b>		First <b>Paul</b>	Middle <b>Douglas</b>
4. DATE OF DEATH <b>11 5 19 67</b>	Month <b>11</b>	Day <b>5</b>	Year <b>19 67</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>8-5-67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David D. Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Barbara G. Adams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mr. David D. Barnes (above address)</b>		Address <b>(Father)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>0571 Meningococcemia and Adrenal hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c)		DUE TO DUE TO DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Arlington Nat. Cem.</b>
20f. (City or town) <b>Arlington</b>		(County) <b>Va.</b>	
(State) <b>11-6-67</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		M.D.	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>Arlington, Va.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/7/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Nat. Cem.</b>
23d. LOCATION (City or Town) <b>Arlington</b>		(County) <b>Va.</b>	
(State) <b>11-6-67</b>			
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 8 1967</b>	25b. REGISTRAR'S SIGNATURE 



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15781

FOR STATE  
HEALTH DEPT.

15790  
 1. PLACE OF DEATH  
 a. COUNTY  
**Prince George's**  
 b. CITY OR TOWN (If outside corporate limits,  
 write RURAL and give nearest town)  
**Cheverly**  
 c. LENGTH OF STAY IN lb  
**DOA**

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

 a. STATE  
**Maryland**  
 b. COUNTY  
**Prince George's**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
**Hyattsville - Rogers Heights**
 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  
**Prince George's General Hospital**

 d. STREET ADDRESS  
**5600 Emerson Street**
e. IS RESIDENCE  
ON A FARM?  
YES  NO 
 3. NAME OF  
DECEASED  
(Type or print)  
 First: **Annie** Middle: **Laura** Last: **Bassette** Month: **11** Day: **5** Year: **19 67**

 4. SEX: **female** 6. COLOR OR RACE: **white** 7. MARRIED:  NEVER MARRIED:   
 WIDOWED:  DIVORCED: 
 8. DATE OF BIRTH: **4-25-29** 9. AGE (in years  
 last birthday) **38** yrs.  
 IF UNDER 1 YEAR: **Months** **Days** **Hours** **Min.**

 10a. USUAL OCCUPATION (Give kind of work done  
 during most of working life, even if retired)  
**Housewife**
 10b. KIND OF BUSINESS OR  
 INDUSTRY: **Own Home**
 11. BIRTHPLACE (State or foreign country)  
**Texas 25, 1**
 12. CITIZEN OF WHAT  
 COUNTRY: **U.S. A.**

 13. FATHER'S NAME: **Sam Shrum**
 14. MOTHER'S MAIDEN NAME: **Laura E. Beall**

 15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (Yes, no, or unknown) (If yes give war or dates of service)  
**no**
 16. SOCIAL SECURITY NO.
 17. INFORMANT  
**Philip Bassette Same as #2 (husband)**

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) **Bilateral pneumonitis**  
 DUE TO  
 492X  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b)  
 DUE TO  
 (c)
 INTERVAL BETWEEN  
 ONSET AND DEATH

 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
 19. WAS AUTOPSY PERFORMED?  
 YES  NO 

 20a. EXTERNAL CAUSE WAS  
 PRIMARY  or CONTRIBUTING   
 CAUSE OF DEATH:  
 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
 20c. TIME OF INJURY Month, Day, Year  
 Hour a.m. **19** 20d. INJURY OCCURRED  
 p.m. While at work  Not White   
 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)  
 20f. (City or town) (County) (State)

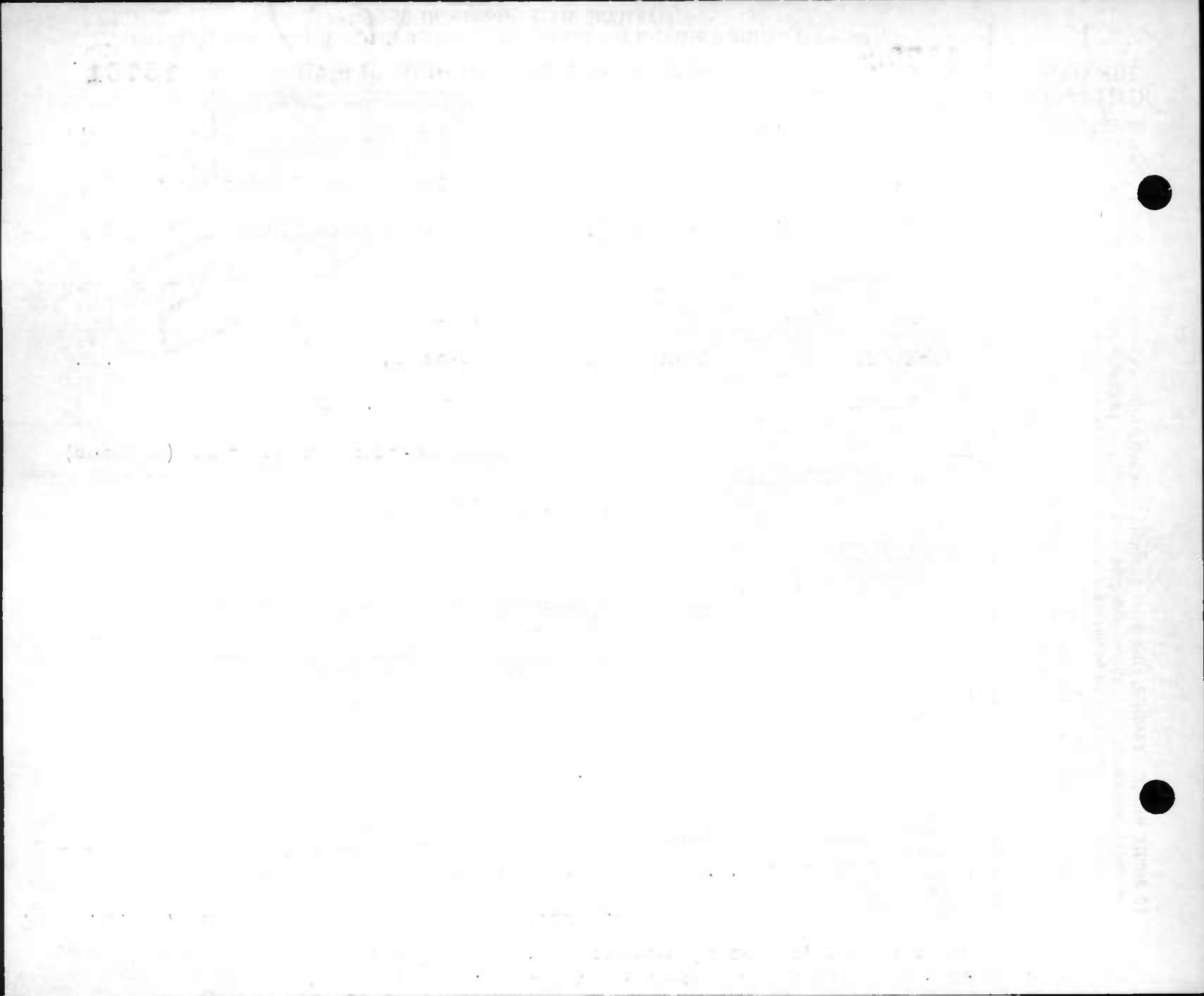
 21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accidents , Suicide , Homicide , Undetermined manner 

 ACTUAL  
 SIGNATURE: *John Kehoe*  
 M.D.  
 EXAMINER'S  
 NAME (Type): **John Kehoe M.D., Riverdale, Maryland**
 CHIEF MEDICAL EXAMINER   
 ASSISTANT MEDICAL EXAMINER   
 DEPUTY MEDICAL EXAMINER   
 Address (Street, city, town, or county)
22. DATE SIGNED  
**11-6-67**
 23a. BURIAL, CREMATION,  
 REMOVAL (Specify) 23b. DATE THEREOF  
**Burial** 11/8/67 23c. NAME OF CEMETERY OR CREMATORIAL  
**Ft. Lincoln**
 23d. LOCATION (City or Town) (County) (State)  
**Colmar Manor, P.G. Md.**

 24. FUNERAL DIRECTOR  
**Francis Gasch's Sons Hyattsville, Md.**
 ADDRESS
 25a. REC'D BY REGISTRAR  
 DATE **NOV 9 1967**
 25b. REGISTRAR'S SIGNATURE  
*Charles Judge*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 page 5 may be retained for your files.

VR A15ME 15  
6M 1/66



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers, fold in half, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 99 days.

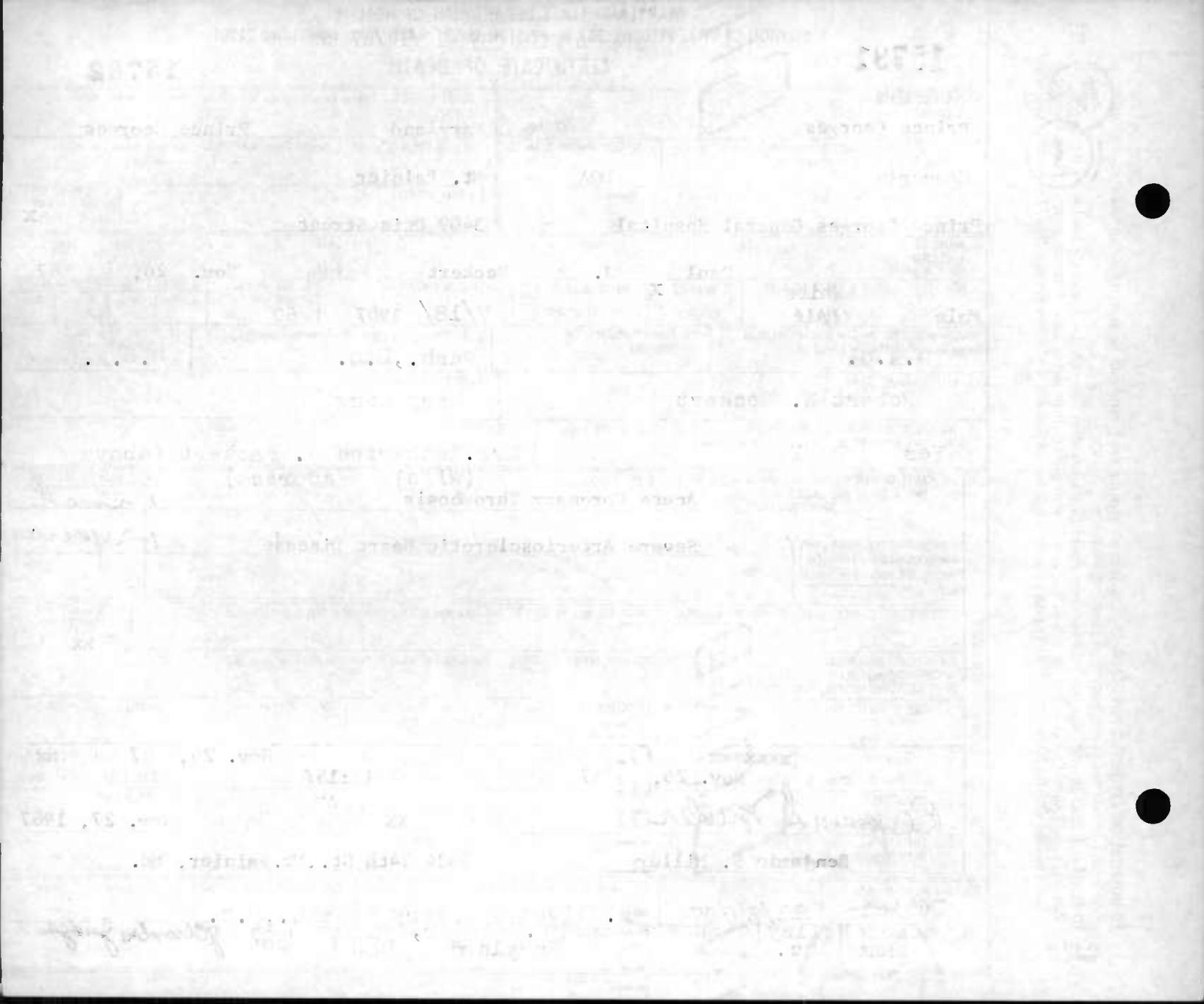
**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15791

**CERTIFICATE OF DEATH**

15782

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN lb <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>3409 Otis Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Paul J. Beckert</b>		First <b>Paul</b>	Middle <b>J.</b>
S. SEX <b>Male</b>	6. COLOR OF RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7/18/ 1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>G.A.U.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Wash., D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert W. Beckert</b>		14. MOTHER'S MAIDEN NAME <b>Mary Krug</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>WWII</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT</b> <b>Mrs. Katherine G. Beckert (above)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		(Wife) address <b>Acute Coronary Thrombosis</b>	
		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1/2 years	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from _____, 19____, to <b>Nov. 26, 1967</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Nov. 26, 1967</b> , and that death occurred at <b>12:15 P.M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>Nov. 27, 1967</b>	
22c. SIGNATURE <b>Benjamin S. Miller</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. AM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <b>3824 34th St., Mt. Rainier, Md.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/29/67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		23d. LOCATION (City or Town) (County) (State) <b>Wash., D.C.</b>	25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>
		25b. SIGNATURE <b>Benjamin S. Miller</b>	DATE



FOR STATE  
1  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15792

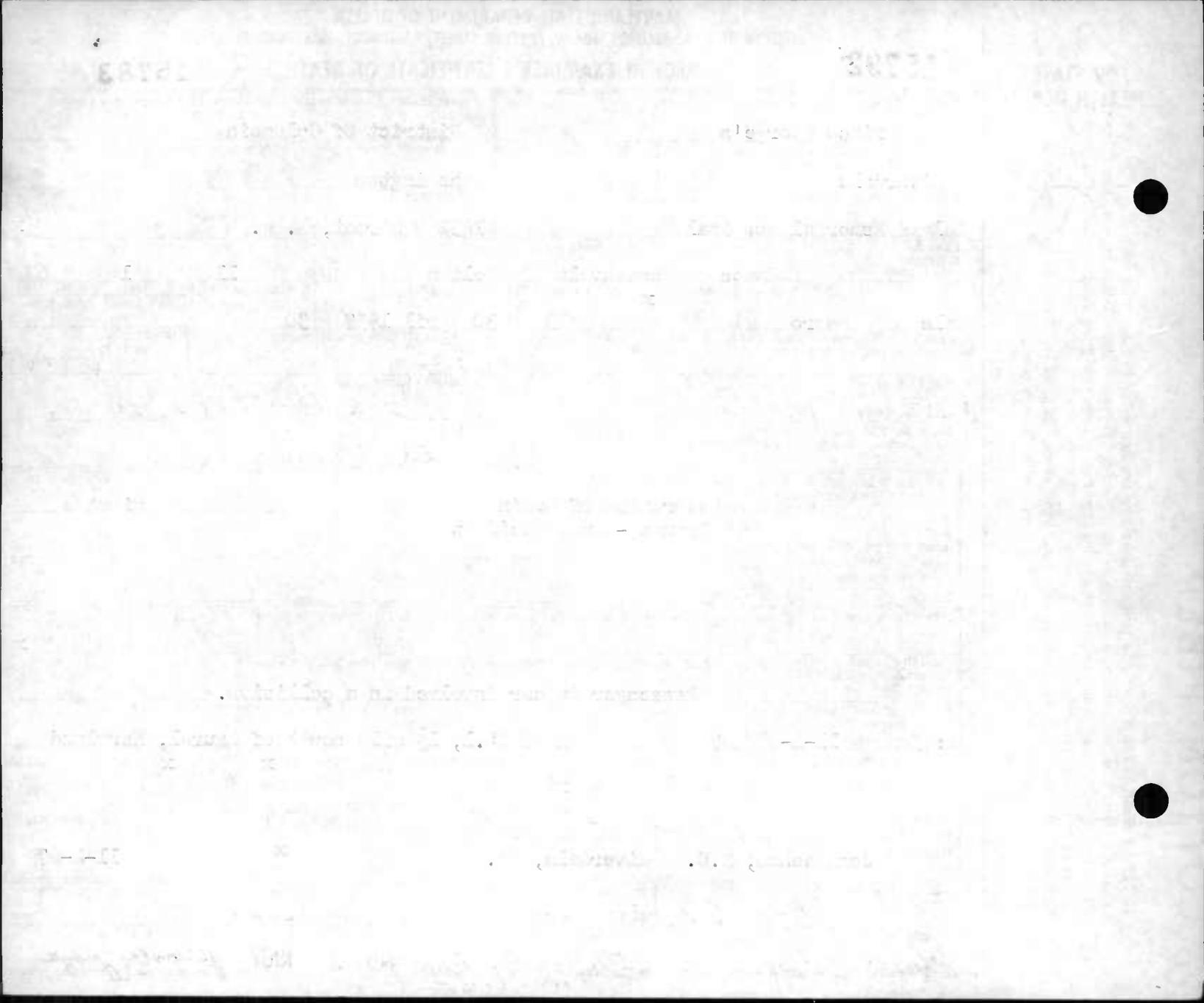
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15783

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District Of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
99		47-3	
3. NAME OF DECEASED (Type or print) <b>James Roosevelt Belton</b>		First <b>James</b>	Middle <b>Roosevelt</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>30 April 1937</b>		9. AGE (In years lost birthday) 30 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>SC.</b>	
11. BIRTHPLACE (State or foreign country) <b>SC.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Calman Belton</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Witherspoon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>Vialda Bella</b>	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> 8164 DUE TO <b>Trauma - auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH minutes	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>4:45pm p.m. 11-1- 19 67</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in car involved in a collision.</b>	
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>US Rt. 1, 1/2 mile south of Laurel, Maryland</b>	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>John Kehoe</i> M.D.		22. DATE SIGNED <b>11-2-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Herchaw SC.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>11-11-67 Church</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church</b>	
23d. LOCATION (City or Town) (County) (State)		23e. REC'D BY REGISTRAR <b>NOV 3 1967</b>	
24. FUNERAL DIRECTOR <b>John D. Water 4983435-14-5100 West D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
ADDRESS		DATE	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15793

## CERTIFICATE OF DEATH

15784

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>15 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Pines - Riverdale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5814 64th Avenue</b>			d. STREET ADDRESS <b>5814 64th Avenue</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Nellie L. Boarman</b>		First <b>Nellie</b>	Middle <b>L.</b>	Lost	4. DATE OF DEATH Month <b>Nov.</b> Day <b>18, 1967</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 3, 1915</b>	9. AGE (In years last birthday) <b>52 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Howard Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Thomas Phillips</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 09 4513</b>		17. INFORMANT <b>Harry E. Boarman Same as #2 (husband)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1992</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO					
CARCINOMATOSIS Primary lesion undetermined } INTERVAL BETWEEN ONSET AND DEATH About 7 to 10 mos }					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-15</b> , 19 <b>67</b> , to <b>11-18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-16</b> 19 <b>67</b> , and that death occurred at <b>6:40 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>David S. Clayman</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>David S. Clayman, M. D.</b>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/21/67</b>		23c. NAME OF CEMETERY OR CEMETORY <b>Western</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		ADDRESS		25a. LOCATION (City or Town) (County) (State) <b>Baltimore, Baltimore Md.</b>	
				25b. REC'D BY REGISTRAR DATE <b>NOV 22 1967</b> Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15785

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH  County <i>Prince George</i>		MARYLAND  MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  a. STATE <i>Maryland</i>		b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  <i>Hyattsville</i>		c. LENGTH OF STAY IN lb  <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  <i>West Hyattsville</i>		d. STREET ADDRESS  <i>3516 Longfellow St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  <i>Hyattsville Nursing Home</i>				e. IS RESIDENCE ON A FARM?  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print)  <i>Dr. Edward John</i>		First	Middle	Last	4. DATE OF DEATH  <i>Boe Nov. 11 1967</i>	Month	Day Year
S. SEX  <i>M</i>	6. COLOR OR RACE  <i>W</i>	7. MARRIED  <input checked="" type="checkbox"/> NEVER MARRIED  <input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	8. DATE OF BIRTH  <i>9-27-84</i>	9. AGE (In years last birthday)  <i>83 yrs.</i>	IF UNDER 1 YEAR  <i>Months Days Hours Min.</i>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  <i>Dentist</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)  <i>Minneapolis, Minn U.S.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME  <i>Louis Boe</i>		14. MOTHER'S MAIDEN NAME  <i>Mary Ryberg</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.  <i>213-38-3420</i>		17. INFORMANT  <i>Nursing Home Records-same as above</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <i>4200</i>		DUE TO  <i>Myocardial Failure</i>		INTERVAL BETWEEN ONSET AND DEATH  <i>5 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)  <i>Arteriosclerotic Heart Disease</i>		DUE TO (c)				<i>15 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <i>Generalized arteriosclerosis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.  <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  <i>3415 Hamilton Street</i>		20f. (City or town) (County) (State)  <i>Hyattsville Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>May 1967</i> to <i>Nov. 1967</i> , that (I) (we) last saw the deceased alive on <i>11 Aug. 1967</i> , and that death occurred at <i>12:30 P.M.</i> from causes and on the date stated above.						22b. DATE SIGNED  <i>11 Nov. 67</i>	
22a. SIGNATURE  <i>Wm. A. Wimsatt</i>		M.D. ATTENDING PHYS.  <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type)  <i>Wm. A. Wimsatt</i>		22d. ADDRESS  <i>3415 Hamilton Street</i>					
23a. BURIAL CREMATION REMOVAL (Specify)  <i>11/14/67</i>		23b. DATE THEREOF  <i>11/14/67</i>		23c. NAME OF CEMETERY OR CREMATORIUM  <i>Ft. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State)  <i>Prince Georges Co. Md.</i>	
24. FUNERAL DIRECTOR  <i>The S. H. Hines CO. INC. Washington, D. C. 20009</i>				25a. REC'D BY REGISTRAR  <i>NOV 14 1967</i>		25b. REGISTRAR'S SIGNATURE  <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

5  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5, page 5, may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		d. STREET ADDRESS <b>612 Addison Road</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Mae</b>	Middle <b>Eliz.</b>	Last <b>Boswell</b>	4. DATE OF DEATH <b>11</b>	Month <b>1</b>	Day <b>19</b>	Year <b>67</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>20 March 1890</b>	9. AGE (In years last birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>William E. Loveless</b>				14. MOTHER'S MAIDEN NAME <b>Alice Grimes</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-05-1380</b>		17. INFORMANT <b>Harry G. Boswell-Same as Item #2.</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b>						INTERVAL BETWEEN ONSET AND DEATH minutes		
<b>443X</b>		DUE TO <b>Hypertensive cardio vascular disease</b>				<b>over 10 yrs.</b>		
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. { (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11-2-67</b>		
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/4/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Trinity Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Upper Marlboro, Md.</b>		
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>NOV 14 1967</b>		



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

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**CERTIFICATE OF DEATH**

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>XX8XX8XMXXXXXXXN</b> Washington, D.C. ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Maurice H. Bowers</b>		First	Middle
4. DATE OF DEATH <b>11 - 27 - 1967</b>	Last	Month	Day
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>10/31/02</b>	9. AGE (In years last birthday) <b>65 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Raleigh Bowers</b>		14. MOTHER'S MAIDEN NAME <b>Nell McCulery</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-intestinal hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>294X</b> 1 week DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <b>Polycythemia vera</b> 6 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic alcoholism; peripheral neuropathy; chronic brain syndrome</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/19/ 1967</b> , to <b>11/27/ 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/27/1967</b> , and that death occurred <b>10:55 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED <b>11/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-1-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Fair Sencolor</b>
24. FUNERAL DIRECTOR <b>Robert A. Mattingly</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince George Co. Md.</b>	25a. RECEIVED BY REGISTRAR <b>Charles Judge</b>
		25b. REGISTRAR'S SIGNATURE	DATE <b>Nov 20 1967</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>5mos., 3wks.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1617 T St., S. E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dorothy L. Bowie</b>		First	Middle
4. DATE OF DEATH <b>11 7 1967</b>	Month	Doy	Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>unknown</b>	8. DATE OF BIRTH <b>10/30/1913</b>
9. AGE (In years last birthday) <b>54 yrs.</b>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife?</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-03-1613</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO <b>Recurrent cerebrovascular accidents with encephalomalacia</b> (c) years			
INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that <b>(s)</b> (this hospital) attended the deceased from <b>5/17/67</b> , to <b>11/7/1967</b> , that <b>(s)</b> (we) last saw the deceased alive on <b>11/7/1967</b> , and that death occurred at <b>2:40 AM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>11/7/67</b>	
22a. SIGNATURE <b>Moe Weiss</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital</b> <b>Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-11-67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>HARMONY MEMORIAL PARK</b>	
23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEORGE'S, MARYLAND</b>		23e. ADDRESS	
24. FUNERAL DIRECTOR <b>Robert J. Phamaco</b>		25a. REC'D BY REGISTRAR <b>30N-12-577E</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
		DATE <b>NOV 13 1967</b>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15789

## CERTIFICATE OF DEATH

1		15798		2		23		3		4		5		6	
<b>TO HOSPITAL OR ATTENDING PHYSICIAN:</b> The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.		<b>10 FUNERAL DIRECTOR:</b> After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7/2 hours after death.													
1. PLACE OF DEATH a. COUNTY		Princ <sup>e</sup> Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		b. STATE		3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Forestville		c. LENGTH OF STAY IN lb		Elouard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		St. Petersburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Regent Nursing & Rehab Center		23 d ays		d. STREET ADDRESS		815 7 <sup>th</sup> ave South		4. DATE OF DEATH		Month November 23 1967			
3. NAME OF DECEASED (Type or print)		First Winfield	Middle S.	Lost Boyce	Month	Doy	Year								
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6-9-1892	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		Retired - 4-5.6 cent		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME		Unknown		14. MOTHER'S MAIDEN NAME		Unknown		USA							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
						Mrs. Betty L. Ronkote - 7733 Wallingacea		Apt. 202							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cancer of Stomach						INTERVAL BETWEEN ONSET AND DEATH							
151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)		DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)													
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from 11-16 1967, to 11-23 1967, that (I) (we) last saw the deceased alive on 11-23 1967, and that death occurred at 210 M, from causes and on the date stated above.															
22a. SIGNATURE John F. Shay						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-23-67			
22c. PHYSICIAN'S NAME (Type) Dr. John F. Shay				22d. ADDRESS 5509-Old Silver Hill Rd SE, Suitland Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 27-1967		23c. NAME OF CEMETERY OR CREMATORI Washington Nat'l Cemetery		23d. LOCATION (City or Town) Suitland,		(County)		(State)					
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS 1661-Good Hope Rd SE Wash DC				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles J. ...							
						DATE NOV 27 1967									
VR A15 1/4 25M 1/8															

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Items 20a-20f-film #395 MARYLAND STATE DEPARTMENT OF HEALTH  
12-12-67 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15799

CERTIFICATE OF DEATH

15790

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY PRINCE GEORGES'	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 8 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First James Middle DAVID Lost Breen		4. DATE OF DEATH Month November 18, 1967	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/29/17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		9. AGE (In years lost birthday) yrs. 49	
13. FATHER'S NAME HERBERT A. BREEN		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES w. W. II		12. CITIZEN OF WHAT COUNTRY? U.S.	
16. SOCIAL SECURITY NO. 154 07 0731		17. INFORMANT MRS ELINOR J. BREEN Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 902.7 DUE TO Respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO HYPOSTATIC PNEUMONIA (c) DUE TO Fracture, right hip			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) ① Parkinsonism ② Severe hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year ? Hour o.m. 11 10 1967		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Patient fell in nursing home leaving bed	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) Nursing home	
20f. (City or town) Greenbelt		(County) Pr. Geo. (State) Md	
21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1967, to Nov. 18, 1967, that (I) (we) last saw the deceased alive on Nov. 18, 1967, and that death occurred at 3:55 AM, from causes and on the date stated above.			
22a. SIGNATURE Arnold G. Brody, M. D.		22b. DATE SIGNED 11/18/67	
22c. PHYSICIAN'S NAME (Type) Arnold G. Brody, M. D.		22d. ADDRESS Prince George's General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov 21, 1967	
23c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEM.		23d. LOCATION (City or Town) COLMAR MANOR, Md. (County) (State)	
24. FUNERAL DIRECTOR ADDRESS w. w. Chambers Co Riverdale, Md.		25a. REC'D BY REGISTRAR DATE NOV 22 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. ...	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville Md.</i>		c. LENGTH OF STAY IN lb <i>6 wks.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville 8800 Wheaton</i>		d. STREET ADDRESS <i>12924 Dean Road</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hyattsville Nursing Home 6500 Ridge Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Harry</i>		First	Middle <i>Willis</i>	Last <i>Bridges</i>	4. DATE OF DEATH <i>Nov. 25</i>	Month <i>Nov.</i>	Doy <i>25</i>	Year <i>1967</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>88</i>	9. AGE (In years last birthday) <i>78 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>		IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookbinder</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Nashville Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>John Bridges</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-40-5796</i>		17. INFORMANT <i>Mrs. James Hart Address 12924 Dean Road Wheaton, Maryland</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4200</i>		Pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Due to <i>Arteriosclerotic Heart Disease</i>		year				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral thrombosis</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1967</i> , to <i>11-25, 1967</i> , that (I) (we) lost saw the deceased alive on <i>11-23 1967</i> , and that death occurred at <i>11 A.M.</i> from causes and on the date stated above.								
22a. SIGNATURE <i>Donald C. Edgren</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>11-25-67</i>		
22c. PHYSICIAN'S NAME (Type) <i>DONALD C. EDGREN</i>		22d. ADDRESS <i>350 East-West Highway Hyattsville, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov 27, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Parklawn Cemetery 8434 Georgia Ave.</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>		
24. FUNERAL DIRECTOR <i>Thomas Warner E. Lumpfrey, Inc.</i>				25a. REC'D. BY REGISTRAR <i>Charles J. Dugay</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Dugay</i>		
VR A15 (4) 25M 1/67				DATE <i>NOV 28 1967</i>				

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 8 Film 6399 11/27/67 RR  
**CERTIFICATE OF DEATH**

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1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORESTVILLE</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DISTRICT HEIGHTS</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>REGENCY NURSING CENTER</b>			d. STREET ADDRESS <b>7821 GATEWOOD BLVD.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16-1				
3. NAME OF DECEASED (Type or print)	First <b>FRANK</b>	Middle <b>P.</b>	Last <b>Brocken</b>	4. DATE OF DEATH <b>Dec. 30, 1879</b>	Month <b>Nov</b> Doy <b>14</b> Year <b>1967</b>	
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1878</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JAMES W. BROWN</b>			14. MOTHER'S MAIDEN NAME <b>SARAH MALCOLM</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MARGARET B. TRUESDELL SAME AS # 2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> 4201 DUE TO (b) <b>Cerebral Vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Generalized Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19 to <b>Nov. 14</b> , 1967, that (we) last saw the deceased alive on <b>Nov. 13</b> 1967, and that death occurred at <b>6 1/2 M</b> , from causes and on the date stated above.						
22a. SIGNATURE <i>WB Sheer</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11-14-67</b>	2028
22c. PHYSICIAN'S NAME (Type) <b>WALTER B. SHEER</b>		22d. ADDRESS <b>6400 Marlboro Pike S.E. WASH D.C.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>11/17/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>CEDAR HILL CREMATORIAL</b>		23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, PRINCE GEORGES, MD</b>
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 25M 1/67						

SECRET

REF ID: A65945

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STURGEON BAY 159

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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CERTIFICATE OF DEATH				15794			
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton, Maryland</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pine View Garden's Health Care Center</b>				<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Temple Hills</b> d. STREET ADDRESS <b>5114 Fisher Dr.</b>			
<b>3. NAME OF DECEASED (Type or print)</b> First <b>Katie</b> Middle <b>M</b> Last <b>Bucheler</b>				<b>4. DATE OF DEATH</b> Month <b>11</b> Day <b>28</b> Year <b>1967</b>			
<b>5. SEX</b> <b>F</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2-8-86</b>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Bu. of Engraving (Exam)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Government</b>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <b>Wash. D.C.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>James Summers</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Alice Posey</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>578-08-24499</b>		<b>17. INFORMANT</b> <b>M. Hart, RN</b>		Address <b>Oxon Hill, Md</b>	
<b>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>CONGESTIVE HEART FAILURE</b> <span style="float: right;"><b>INTERVAL BETWEEN ONSET AND DEATH</b></span> <b>4200</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b) ARTERIO SCLEROTIC HEART DISEASE 3 months</b> <b>(c) GENERALIZED ARTERIO SCLEROSIS</b>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>CEREBRAL VASCULAR DISEASE</b>							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from <b>9-21</b>, 19<b>67</b>, to <b>11-28</b>, 19<b>67</b>, that (I) (we) last saw the deceased alive on <b>11-28-67</b> 19<b>67</b>, and that death occurred at <b>8</b> M, from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Alfred Laren Jr.</b>				<b>22b. DATE SIGNED</b> <b>1967</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>ALFRED R. LAREN JR.</b>		<b>22d. ADDRESS</b> <b>Clinton, MD</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/1/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <b>Cedar Hill</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>Suitland, Md.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Lee Funeral Home</b>				<b>ADDRESS</b> <b>Washington, D.C.</b>		<b>25a. RECD BY REGISTRAR</b> <b>DEC 4 1967</b>	
						<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

15795

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
o. COUNTY <b>Prince Georges</b>		o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale, Maryland</b>		c. LENGTH OF STAY IN lb <b>1 month</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood, Maryland</b>		d. STREET ADDRESS <b>4538 41st Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ora M. Bullock</b>		First	Middle
S. SEX <b>Fe</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
13. FATHER'S NAME <b>George W. Bullock</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Mary Simonett</b>	
16. SOCIAL SECURITY NO. <b>213-12-1560</b>		17. INFORMANT <b>Mr. Philip C. Bullock-Arlington, Va. - Son</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Gangrene of leg</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>	
DUE TO (b) DUE TO (c)		<b>Cerebral thromboses</b>	
		<b>Tender Paroxysm Sclerosis</b>	
		<b>5 day</b>	
		<b>underlying</b>	
		<b>me</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Carver Memorial Park</b>
20f. (City or town) <b>Laurel, Md.</b>		(County) (State) <b>Laurel, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 15</b> , 19 <b>67</b> to <b>Nov 17</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>Nov 17</b> 19 <b>67</b> , and that death occurred at <b>12 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Lee Malin</b>		22b. DATE SIGNED <b>Nov 24 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>L W MALIN MD Riverdale</b>		M.D. <input type="checkbox"/> ATTENDING PHYS. <b>Carver Memorial Park</b>	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/21/67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Carver Memorial Park</b>		23d. LOCATION (City or Town) <b>Laurel, Md.</b>	
24. FUNERAL DIRECTOR <b>John T. Phillips Co.</b>		ADDRESS <b>3015-12 of 47th</b>	25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15796

## **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		d. STREET ADDRESS <b>4915 Erie Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dorothea Katherine</b>		First	Middle	Lost	4. DATE OF DEATH Month <b>11</b>	Month	Day Year <b>5 1967</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-27-13</b>	9. AGE (In years lost birthday) <b>54 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days Hours Min. <b>0 0 0</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE + CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEWART MOTOR CO</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>John Copp</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Schaeffer</b>		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Harry G. Burd, Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> <b>583 X</b>		DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH MONTHS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. {							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11-6-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		ADDRESS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 8, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	23d. LOCATION (City or Town) <b>Bladensburg, Maryland</b>	(County)	(State)	
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO. Riverdale, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 9</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

GENERAL DIRECTION. Page 3 shall

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

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**CERTIFICATE OF DEATH**

15787

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY      Prince George      MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE      Maryland      b. COUNTY      Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 18 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		d. STREET ADDRESS 7548 Newberry Lane		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Douglas	Middle Christian	Lost Butler	4. DATE OF DEATH Nov. 19, 1967	Month Nov.	Doy 19, 1967	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1966	9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Prince George Co, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Linwood C. Butler Jr.				14. MOTHER'S MAIDEN NAME Barbara Dinsmore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Linwood C. Butler Jr. Same as #2 (father)		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  180X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 2 weeks  DUE TO (b) DUE TO (c)  Wilm's tumor of kidneys				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.      19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 10/13/66, 19 to Nov 19, 1967, that (I) (we) last saw the deceased alive on Nov 18, 1967, and that death occurred at 1:10 AM, from causes and on the date stated above.								
22a. SIGNATURE <i>Gordon W. Kelly</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/20/67		
22c. PHYSICIAN'S NAME (Type) Gordon W. Kelly, M.D.		22d. ADDRESS 6124 41st Ave. Hyattsville, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/67		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland Prince George Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE Nov 21 1967		
						25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15805

CERTIFICATE OF DEATH

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Hghts</b>		f. STREET ADDRESS <b>630 61st Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
16-1									
3. NAME OF DECEASED (Type or print)		First <b>Mary</b>	Middle <b>E.</b>	Lost <b>Cain</b>	4. DATE OF DEATH <b>Nov. 23,</b>	Month <b>Nov.</b>	Doy <b>23</b>	Year <b>1967</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>X/22/79</b>	9. AGE (In years lost birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months <b>XX</b>	IF UNDER 24 HRS. Doys <b>XX</b>	Hours <b>XX</b>	Min. <b>XX</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John J. Kefe</b>		14. MOTHER'S MAIDEN NAME <b>Margaret C. Faulkner</b>		15. SOCIAL SECURITY NO.		16. INFORMANT <b>Mary A. Seipp</b>		Address <b>Same As # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub Dural Hematoma</b>								INTERVAL BETWEEN ONSET AND DEATH	
331X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 8, 1967</b> , to <b>Nov. 23, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 23, 1967</b> , and that death occurred at <b>11:50A</b> , from causes and on the date stated above.									
22a. SIGNATURE <i>Arnold G. Brody</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		P. M. MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M. D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/27/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 30 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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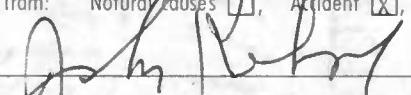
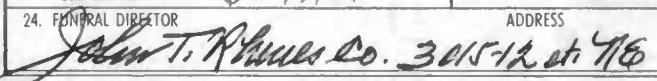
#### Conclusions

30

~~FOR STATE  
HEALTH DEPT.~~

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #23a, b, c & d Film #G394 11/15/67 ph MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>1717 Franklin Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
99										47-3	
3. NAME OF DECEASED (Type or print)		First <b>Fleada</b>	Middle <b>Gordon</b>	Last <b>Cameron</b>	4. DATE OF DEATH <b>11 3 19 67</b>	Month Year	Month Year	Doy Year	Doy Year		
S. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-13-19</b>	9. AGE (In years lost birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	Hours <b>0</b>	Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>York City, S. C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Henry Gordon</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Steele</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>John R. Cameron-1717 Franklin Street, NE</b>		Address		Husband			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>8164</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				<b>LACERATION OF BRAIN</b>				INTERVAL BETWEEN ONSET AND DEATH <b>None.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>passenger in car involved in collision</b>									
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>12:20pm p.m. 11-3 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 1 at Naples Road, Prince George's, Md.</b>		20f. (City or town) <b>Prince George's, Md.</b>		(County) <b>Md.</b>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <b>11-4-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		Address (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Lincoln Memorial Cemetery</b>		23d. LOCATION (City or Town) <b>Suitland</b>		(County) <b>P.G.</b>		(State) <b>Md.</b>	
24. FUNERAL DIRECTOR 		ADDRESS				25a. REC'D BY REGISTRAR <b>NOV 10 1967</b>		25b. REGISTRAR'S SIGNATURE 			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15800

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>												
<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE</u> MARYLAND						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>			c. LENGTH OF STAY IN lb <u>5 months</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLS CHURCH</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>M. GROW Hospital</u>						d. STREET ADDRESS <u>7107 NORWACK ST</u>						
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <u>William</u>		First <u>G.</u> Middle <u>Campbell</u> Jr				<b>4. DATE OF DEATH</b> <u>NOV 23 1967</u>		Month		Doy	Year	
S. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 JULY 25</u>		9. AGE (In years last birthday) <u>42 yrs.</u>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NAVIGATOR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>USA F</u>			11. BIRTHPLACE (County & State, or foreign country) <u>LAS VEGAS, NEW MEXICO</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
<b>13. FATHER'S NAME</b> <u>William C. Campbell Jr</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Sleister, Jesse</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 1942 - 1967</u>			16. SOCIAL SECURITY NO. <u>454-26-6472</u>			17. INFORMANT <u>Nancy Campbell (wife)</u>			Address <u>7107 NORWACK ST</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>593 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>GASTRITIS</u> DUE TO (c) <u>LUPES NEPHRITIS</u>												
INTERVAL BETWEEN ONSET AND DEATH												
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>HYPERTENSION, CONGESTIVE HEART FAILURE</u>												
<b>20a. MEDICAL CERTIFICATION</b> ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
<u>19</u>												
<b>21.</b> I certify that (H) (this hospital) attended the deceased from <u>16 MAY 1967</u> to <u>23 NOV 1967</u> , that (H) (we) last saw the deceased alive on <u>23 NOV 1967</u> , and that death occurred at <u>0720</u> M, from causes and on the date stated above.												
<b>22a. SIGNATURE</b> <u>Michael S. Goldstein</u>						<b>22b. DATE SIGNED</b> <u>Nov 23, 1967</u>						
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Michael S. Goldstein</u>						<b>M.D. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>Malcolm Grow Hosp.</u>						
<b>23a. BURIAL/CREMATION, REMOVAL (Specify)</b> <u>11-28-67</u>			<b>23b. DATE THEREOF</b> <u>11-28-67</u>			<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <u>ARLINGTON NAT'L.</u>			<b>23d. LOCATION (City or Town) (County) (State)</b> <u>ARLINGTON, VA</u>			
<b>24. FUNERAL DIRECTOR</b> <u>FALLS CHURCH F. H.</u>						<b>1102 Broad St.</b>			<b>25a. REC'D BY REGISTRAR</b> <u>NOV 27 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judd</u>	

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5) von E. F. W. WAMMEL  
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Fab. 100M.P.E.S.

Geachte voorzitter en leden van de commissie voor de volksvertegenwoordiging,

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15809

CERTIFICATE OF DEATH

15801

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>P. G.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews AFB</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND, MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Andrews Air Force Hospital</b>		d. STREET ADDRESS <b>4704 CHERYL LANE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>IDA</b>	Middle <b>CAPANO</b> Last
4. DATE OF DEATH Month <b>11</b> Day <b>5</b> Year <b>1967</b>	5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>MAY 10, 1899</b>	9. AGE (In years last birthday) <b>68</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most recent work lifetime, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>PHILADELPHIA PA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES JANNETTI</b>		14. MOTHER'S MAIDEN NAME <b>JOSEPHINE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>CHARLES DE CESARIS</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>ACUTE MYOCARDIAL INFARCTION</b> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC C.V. DISEASE</b> DEATH AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>White</b> Nat White p.m. <b>19</b> at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1967</b>		20f. (City or town) <b>1967</b> (County) <b>to 11-5-1967</b> (State) <b>M.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1967</b> , to <b>11-5-1967</b> , that (I) (we) last saw the deceased alive on <b>1967</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Benjamin Specson</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>BENJAMIN SPECSON M.D.</b>		22d. ADDRESS <b>6106 OLD SILVER HILL ROAD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-9-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>
23d. LOCATION (City or Town) <b>Suitland</b>		(County) <b>Maryland</b> (State)	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home Suitland Md</b>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE DATE <b>NOV 10 1967</b> <b>J Charles Juge</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #23c Film #G395 11/21/67 ph

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

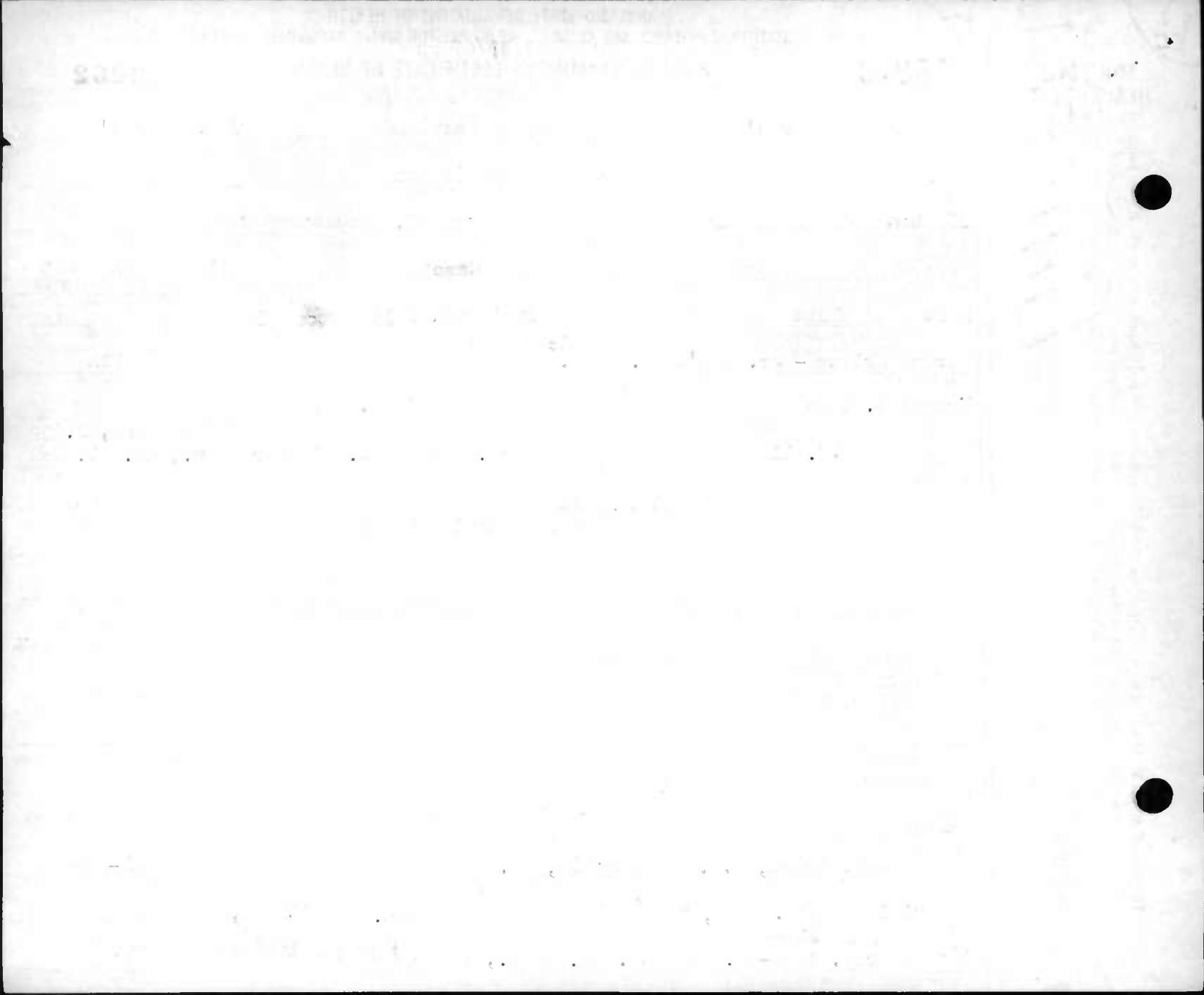
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1-2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15810

15802

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Clinton Medical Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Leon Sherman Case</b>		First <b>Leon</b>	Middle <b>Sherman</b>
4. DATE OF DEATH <b>11 12 1967</b>	Month <b>11</b>	Day <b>12</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. B. DATE OF BIRTH <b>27 Dec. 1915</b>		9. AGE (In years lost birthday) <b>51 yrs.</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver - Pr. Geo's Co. Dept. Of</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Ernest A. Case</b>		14. MOTHER'S MAIDEN NAME <b>Sophia A. Povagh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW. II</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT Mrs. Dorothy A. Windsor (Dan.) Rt. # 1. Box</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address <b>Clinton, MD. 422</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4200</b>		INTERVAL BETWEEN ONSET AND DEATH minutes <b>unknown</b>	
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Suitland, Maryland</b>
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		22. DATE SIGNED <b>11-13-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 15th, 67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>		23e. ADDRESS <b>1661-Gd. Hope Rd. SE. Wash., DC</b>	
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15811

CERTIFICATE OF DEATH

15803

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Pr.Geo.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr.Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 26 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		d. STREET ADDRESS 3020 - Laurel Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3020 - Laurel Ave.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Catherine	Middle M.	Last Clements	4. DATE OF DEATH Nov. 1 1967	Month Nov.	Day 1	Year 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDDWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVDRCD <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1878	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ephraim McKenna				14. MOTHER'S MAIDEN NAME Johanna Corbett				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-56-2477		17. INFORMANT Miss Matilda E. Clements (above address) (daughter) dress		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1561 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO Pulmonary Edema DUE TO Atherosclerotic Heart Disease (c) Gastro Uremic Jaundice		INTERVAL BETWEEN ONSET AND DEATH 3 months 3 days 6 months				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 1965, to 11-1-1967, that (I) (we) last saw the deceased alive on 11-1-1967, and that death occurred at 930 M. fram causes and on the date stated above.				22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) CHARLES SADAKYAN		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 6001 LANDOVER Rd. Cheverly				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/6/67		23c. NAME OF CEMETERY OR CREMATORIUM Mt.Olivet Cemetery		23d. LOCATION (City or Town) Washington, D.C. (County) (State)		
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE NOV 8 1967 Charles George		

4

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15812

## CERTIFICATE OF DEATH

15804

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.****TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>	c. LENGTH OF STAY IN TB <b>1 MONTH</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>	d. STREET ADDRESS <b>6623 24TH. AVENUE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUITLAND NURSING HOME INC.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>FORTUNATA</b>	Middle <b>COLLETTI</b>	4. DATE OF DEATH Month <b>11</b> Month <b>15</b> Doy Year <b>1967</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-6-68</b>
9. AGE (In years lost birthday) <b>99 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. DAYS <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PETER GRECO</b>		14. MOTHER'S MAIDEN NAME <b>GATANA GERVERSIA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-54-8120</b>	
17. INFORMANT		Address <b>MRS. ROSE NASH SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>444X</b> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
<b>HYPERTENSION</b> <b>4 WEEKS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CEREBRAL ISCHEMIA</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/17</b> , 19 <b>67</b> , to <b>11/15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10/17/67</b> , and that death occurred at <b>9:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Bruno Kolegn M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>BRUNO KOLEGN M.D.</b>		22d. ADDRESS <b>4400 SAMP Rd. SE MARLOW HEIGHTS - MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-18-67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>MT OLIVET CEMETERT</b>	23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON D. C.</b>
24. FUNERAL DIRECTOR <b>J. Francis J. Collins</b>		ADDRESS <b>WASH. D.C.</b>	25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

SABRE

AMERICA

DATE 10. 31. 1962

SEARCHED - INDEXED

OK

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15805

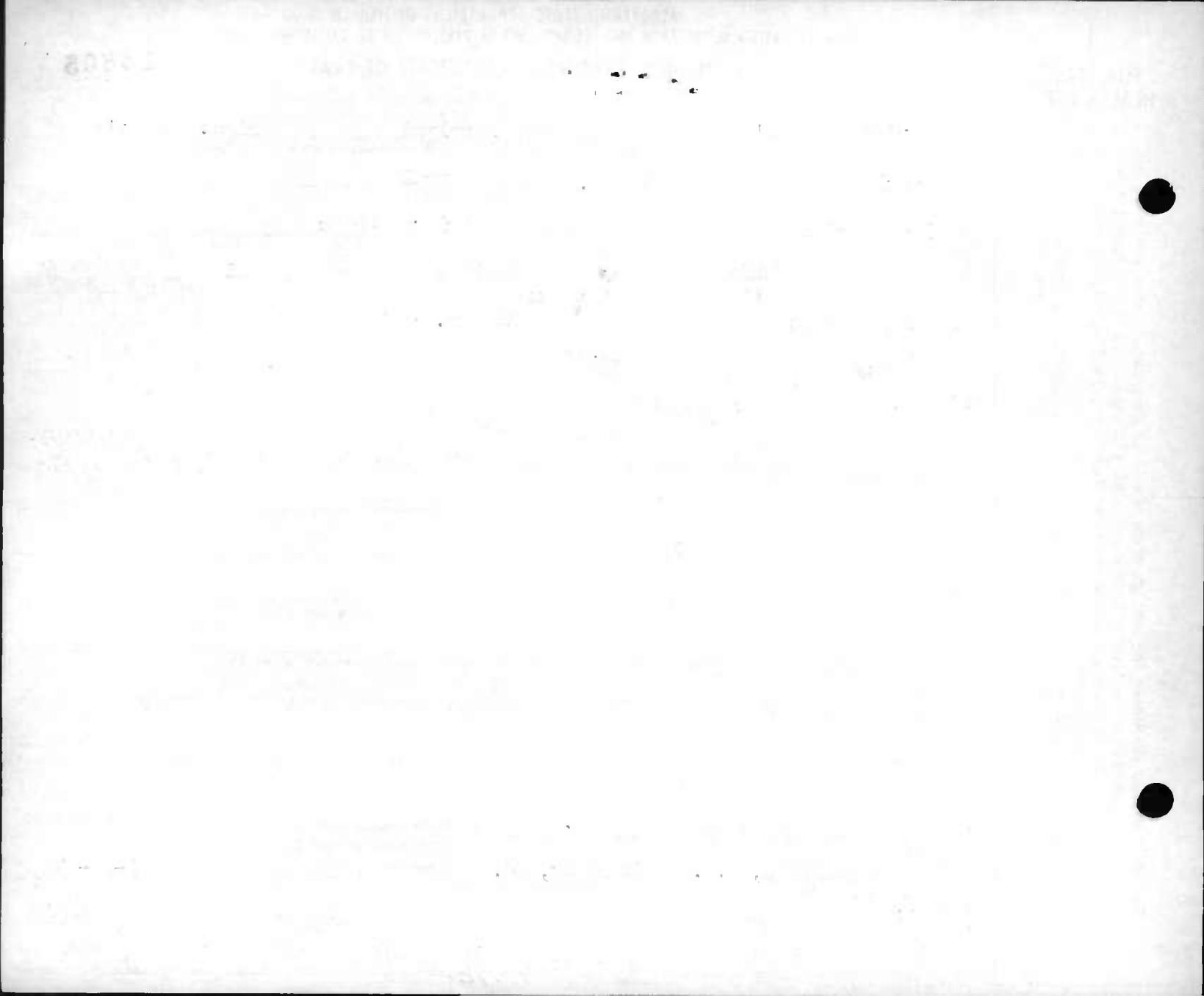
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY <b>Prince George's</b>		b. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		c. LENGTH OF STAY IN lb <b>2 1/2 mo.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>		d. STREET ADDRESS <b>14101 Dub Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>14101 Dub Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lissa</b>		First <b>Anne</b>	Middle <b>Collins</b>
4. DATE OF DEATH <b>11</b>		Month <b>16</b>	Doy <b>19</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH <b>26 Aug. 1967</b>		9. AGE (In years lost birthday) — yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Dr. JAMES JOSEPH COLLINS</b>	
14. MOTHER'S MAIDEN NAME <b>—</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Dr. JAMES J. Collins 14101 Dub Drive, Laurel, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7952</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>SDII</b> DUE TO (b) (c)		Address <b>14101 Dub Drive, Laurel, Md.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>
20f. (City or town) <b>—</b>		(County) (State) <b>—</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>11-17-67</b>	
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>—</b>
24. FUNERAL DIRECTOR <i>Charles Judge</i>		23d. LOCATION (City or Town) <b>SPRINGFIELD</b>	
		(County) (State) <b>—</b>	
25a. REC'D BY REGISTRAR DATE <b>NOV 21 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15813

**CERTIFICATE OF DEATH**

15806

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. LENGTH OF STAY IN lb <b>4 mo</b>		e. STREET ADDRESS <b>1500 Oak View Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PINEVIEW GARDENS</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BLANCHE L COLLIS</b>		4. DATE OF DEATH Month Day Year <b>11 6 1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-2-1883</b>
9. AGE (In years lost birthday) <b>84 yrs.</b>		10. BIRTHPLACE (County & State, or foreign country) <b>West Virginia USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. CITIZEN OF WHAT COUNTRY? <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>West Virginia USA</b>	
13. FATHER'S NAME <b>John Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Beth Britton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>236-16-3582-A</b>	
17. INFORMANT <b>M. HART, RN</b>		Address <b>5905 FISHER, WASH.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>AS IAD TO CVA.</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Clinton, MD</b>
20f. (City or town) <b>Clinton</b>		(County) (State) <b>MD</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>7-23, 1967</b> to <b>11-6, 1967</b> , that (I) (we) last saw the deceased alive on <b>11-6, 1967</b> , and that death occurred at <b>87 M.</b> from causes and on the date stated above.			
22o. SIGNATURE <b>Alfred R. Lapin</b>		22b. DATE SIGNED <b>11-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALFRED R. LAPIN MD</b>		22d. ADDRESS <b>Clinton, MD</b>	
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-9-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Bunker Hill Cemetery</b>
23d. LOCATION (City or Town) <b>Martinsburg</b>		(County) (State) <b>West Virginia</b>	
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>		ADDRESS <b>Suitland Md</b>	25o. RECD. BY REGISTRAR <b>No 10 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

80804

140-10-10007

812

RECORDED

ANALYST

CHARGE TRAILED

EVINZ 100% 100% 100%

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MINUTE 100% ANALYST

140-10-10007 140-11 140-

140-10-10007 140-11 140-

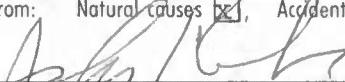
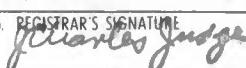
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15814		15808	
<p>1. PLACE OF DEATH            a. COUNTY      Prince George's MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      Cheverly DOA</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)      Prince George's General Hospital</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)            a. STATE      Maryland b. COUNTY      Prince George's</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)      New Carrollton</p> <p>d. STREET ADDRESS      8066 87th Avenue</p>	
<p>3. NAME OF DECEASED (Type or print)      First      Middle      Last      4. DATE OF DEATH      Month      Day      Year</p> <p>Glenn      Weldon      Dameron      11      10      19      67</p>		<p>e. IS RESIDENCE ON A FARM?      YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
S. SEX      6. COLOR OR RACE      7. MARRIED Male      White <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH      9. AGE (In years lost birthday) 9 July 1910      57 yrs.	<p>IF UNDER 1 YEAR      IF UNDER 24 HRS.            Months      Days      Hours      Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)      Analyst</p> <p>10b. KIND OF BUSINESS OR INDUSTRY      N.S.A.</p>		<p>11. BIRTHPLACE (State or foreign country)      Ava. Mo.</p>	
<p>13. FATHER'S NAME      Clarence W. Dameron</p>		<p>12. CITIZEN OF WHAT COUNTRY?      USA</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)      Yes WW. II</p>		<p>16. SOCIAL SECURITY NO.      246-14-3514</p>	
<p>17. INFORMANT      Mrs. Lavinia C. Dameron,</p>		<p>Address      New Carrollton Md.</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))            PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a)      Heart failure            4200      DUE TO Arteriosclerotic heart disease            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause      (b)            lost.      DUE TO            (c)</p>			
<p>INTERVAL BETWEEN ONSET AND DEATH minutes            over 6 mo.</p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)</p>			
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY      Month, Day, Year            Hour o.m.      p.m.      19</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work</p>	<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>
<p>20f. (City or town)      (County)      (State)</p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE              EXAMINER'S NAME (Type)      John Kehoe, M.D.      Riverdale, Md.</p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/>            M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>            DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>            Address (Street, city, town, or county)      11-10-67</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)      Burial</p>		<p>23b. DATE THEREOF      11-13-67</p>	
<p>23c. NAME OF CEMETERY OR CREMATORIUM      Ivy Hill Cemetery</p>		<p>23d. LOCATION (City or Town)      (County)      (State)            Alex., Va.</p>	
<p>24. FUNERAL DIRECTOR      Everly-Wheatley</p>		<p>ADDRESS      A1ex., Va.</p>	
<p>25a. REC'D BY REGISTRAR</p>		<p>25b. REGISTRAR'S SIGNATURE</p>	
<p>DATE NOV 14 1967</p>		<p></p>	

87561



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15815

15809

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Palmer Park</b>		d. STREET ADDRESS <b>7401 85th Avenue</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
74								
3. NAME OF DECEASED (Type or print) <b>(Joseph) Guiseppa</b>		First	Middle	Last	4. DATE OF DEATH <b>Nov. 17, 1967</b>	Month	Doy	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <b>xxx</b>	NEVER MARRIED DIVORCED <b>      </b>	8. DATE OF BIRTH <b>11/20/91</b>	9. AGE (In years lost birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months <b>        </b>	IF UNDER 24 HRS. Hours <b>        </b>	Days <b>        </b>
10. USUAL OCCUPATION (Give kind of work done during last 6 months, life even if retired) <b>Title Setter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S. A.</b>		
13. FATHER'S NAME <b>Zopito D'Arcangelo</b>				14. MOTHER'S MAIDEN NAME <b>Filomena Dinofrio</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579 05 7831</b>		17. INFORMANT <b>Albert D'Arcangelo</b>		750 1/4 Halleck St. (son) Washington D. C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Very severe bronchial pneumonia , bilateral, involving all lobes		INTERVAL BETWEEN ONSET AND DEATH		
(b)		DUE TO		Severe prurulent tracheal bronchitis				
(c)		DUE TO		Coronary Arteriosclerosis				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>    </b> (this hospital) attended the deceased from <b>Oct. 29, 1967</b> , to <b>Nov. 17, 1967</b> , that <b>    </b> (we) last saw the deceased alive on <b>Nov. 17, 1967</b> , and that death occurred at <b>8:00AM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>Arnold G. Brody, M.D.</b>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/18/67</b>		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Prince Georges General Hospital</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/21/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>		
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 22 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Justice</b>		

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items 23c & 23d, Film G101 9/11/68 sac												15810	
15818						CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>3 hrs 20 m</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			b. COUNTY <b>Prince Georges</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>						d. STREET ADDRESS <b>3206 Tremont Avenue</b>							
3. NAME OF DECEASED (Type or print)		First <b>Paul</b>	Middle <b>GEORGE</b>	Last <b>Daston</b>	4. DATE OF DEATH <b>19 Nov., 1967</b>		Month <b>19</b>	Doy <b>19</b>	Year				
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <b>X</b> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Oct., 1921</b>		9. AGE (In years lost birthday) <b>46 yrs.</b>	IF UNDER 1 YEAR Months <b>3206 Tremont Ave.</b>		IF UNDER 24 HRS. Days <b>Cheverly, Md.</b>		Hours <b>15 m</b>	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Profesaor</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Boston, Mass.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>George P. Daston</b>						14. MOTHER'S MAIDEN NAME <b>Zenobia Zarapatis</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>10-2-42 to 9-21-45</b>			16. SOCIAL SECURITY NO. <b>032-09-1797</b>			17. INFORMANT <b>Marie P. Daston (Wife)</b>			Address <b>3206 Tremont Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for, (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> INTERVAL BETWEEN ONSET AND DEATH <b>4201</b>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Ventricular fibrillation</b> 15 m (c) <b>Myocardial infarction</b> 7 hours													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Rheumatic carditis</b>													
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State) <b>11-19</b>				
21. I certify that (I) (this hospital) attended the deceased from <b>12 3 AM 11-19-1967</b> , to <b>5 35 AM 1967</b> , that (I) (we) last saw the deceased alive on <b>11-19-1967</b> , and that death occurred at <b>5 35 AM</b> , from causes and on the date stated above.													
22a. SIGNATURE <b>R. W. Weihraub</b>			M.D. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>11-19</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. W. Weihraub, M.D.</b>			22d. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>22 Nov. 1967</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National Cem.</b>			23d. LOCATION (City or Town) <b>Baltimore, Md.</b>			(County) (State)	
24. FUNERAL DIRECTOR <b>Rinaldi Funeral Home</b>			ADDRESS <b>7400 Georgia Ave NW Washington, D.C. 20012</b>			25a. REC'D BY REGISTRAR <b>NOV 21 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Juges</b>				

3183

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**FOR STATE  
HEALTH DEPT.**

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15817		15811	
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>	
d. STREET ADDRESS <b>503 4 th. Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert PELTON</b>		First <b>Robert</b>	Middle <b>PELTON</b>
4. DATE OF DEATH <b>11 27 1967</b>	Month <b>11</b>	Doy <b>27</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>30 June 1926</b>
9. AGE (In years lost birthday) <b>41 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dispatcher cab stand</b>	11. BIRTHPLACE (State or foreign country) <b>Poughkeepsie N.Y.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Carol Vail Dauchy</b>	14. MOTHER'S MAIDEN NAME <b>Irene Bauer</b>	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	16. SOCIAL SECURITY NO. <b>144-46</b>	17. INFORMANT <b>John Lansley</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral lobar pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last (c)
			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED <b>11-27-67</b>
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-30-67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Tony Hill Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Laurel Md</b>
24. FUNERAL DIRECTOR <b>DeWitt Danaedan Laurel Md</b>	ADDRESS	25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15812

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>30 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>		d. STREET ADDRESS <b>4221 30th St.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>First</b> <b>McKay</b> <b>Middle</b> <b>Dement</b>		Last		4. DATE OF DEATH <b>Nov. 4, 1967</b>		Month Doy Year		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/05</b>	9. AGE (In years last birthday) <b>61 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Dys Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kennett, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George Dement</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Kinder</b>		Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Peacetime</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Francis Smith (Sister)</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1992</b> <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 1967, to <b>Nov. 4</b> , 1967, that (I) (we) lost saw the deceased alive on <b>Nov. 3</b> , 1967, and that death occurred at <b>12:30 P.M.</b> from causes and on the date stated above.						22b. DATE SIGNED <b>11/4/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>William D. Rosson</b>		22d. ADDRESS <b>5701 - 85th Ave., Hyattsville, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/7/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>FORT LINCOLN</b>		23d. LOCATION (City or Town) (County) (State) <b>BIRDSBURG, MD.</b>		
24. FUNERAL DIRECTOR <b>W. W. Chambers Cofel 400 Chapin St. N.W.</b>		ADDRESS <b>Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Oleander Judge</b>		

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oil gas

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Geology, Alberta, British Columbia, Montana, Canada

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Alberta, British Columbia, Canada

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. *Roger J. and 2*

should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 2 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items #10a, 13 & 14 File #6395 12/1/67 ph Items #8 & 9 per birth cert. ph									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>62 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b> d. STREET ADDRESS <b>--</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> First <b>Dorothy</b> Middle <b>N.</b> Last <b>Duckett</b> (Type or print)					<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>18</b> Year <b>1967</b>				
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7/14/27</b>	9. AGE (In years <b>89</b> , last birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months <b>Days</b> Hours <b>Min.</b>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Charles County, MD</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Duckett</b>					14. MOTHER'S MAIDEN NAME <b>Elise Roberson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT <b>Dorothy Shorter</b>					Address <b>Daughter</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrolyte imbalance</b> <b>5720</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>multiple Gastrointestinal &amp; urinary fistulas</b> DUE TO (c) <b>Regional ileitis</b>									
INTERVAL BETWEEN ONSET AND DEATH									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. MEDICAL CERTIFICATION</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Newtown</b> (County) <b>MD</b> (State)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Nov. 18</b>									
<b>21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 17</b>, 1967, to <b>Nov. 18</b>, 1967, that (I) (we) last saw the deceased alive on <b>Nov. 18</b>, 1967, and that death occurred at <b>7:05 A.M.</b> from causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <i>Ricardo Longoria</i>					<b>22b. DATE SIGNED</b> <b>11/18/67</b>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Ricardo Longoria, M.D.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11/23/67</b>		23c. NAME OF CEMETERY OR CEMINATORY <b>St. Matthew's Church Cemetery</b>		23d. LOCATION (City or Town) <b>Newtown</b> (County) <b>MD</b> (State)			
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD. BY REGISTRAR <b>NOV 21 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
<i>Leroy E. Berry Funeral Home</i>									

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15814

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <i>PRINCE GEORGES</i>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>LAUREL</i>		b. COUNTY <i>PRINCE GEORGES</i>	
c. LENGTH OF STAY IN 1b <i>72</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LAUREL</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>LAUREL GEN. HOSPITAL</i>		d. STREET ADDRESS <i>335 TALBERT AVE.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH <i>NOV. 24, 1967</i>	
3. NAME OF DECEASED (Type or print)	First <i>LENA</i>	Middle <i>MARY</i>	Last <i>ELDER</i>
4. DATE	Month <i>NOV.</i>	Day <i>24,</i>	Year <i>1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT 4, 1893</i>
9. AGE (In years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/>	11. IF UNDER 24 HRS <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>
13. FATHER'S NAME <i>LORENZO NESTLE RODE</i>	14. MOTHER'S MAIDEN NAME <i>ELLA HUFF</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <i>ETHER J MARTON, 111 DORSET RD. LAUREL, MD.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac failure + anemia</i>			
DUE TO (b) <i>Hepatomegaly</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Some,</i>			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <i>19</i>	Month, Day, Year p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>DUNNSTOWN</i> (County) <i>Montgomery</i> (State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from ..... 1960 to 11-24, 1967, that (I) (we) last saw the deceased alive on 11-23, 1967, and that death occurred at 3PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Solo Lienander</i>	22b. DATE SIGNED <i>11/24/67</i>		
22c. PHYSICIAN'S NAME (Type)	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. ADDRESS <i>550 WASH BLDG.</i>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Nov 28, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>DUNNSTOWN CEMETERY</i>	23d. LOCATION (City, town or county) <i>DUNNSTOWN</i> (State) <i>Penns</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Septimus Mullings</i>	ADDRESS <i>LAUREL</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
DATE <i>NOV 28 1967</i>		DATE <i>NOV 28 1967</i>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15821

15815

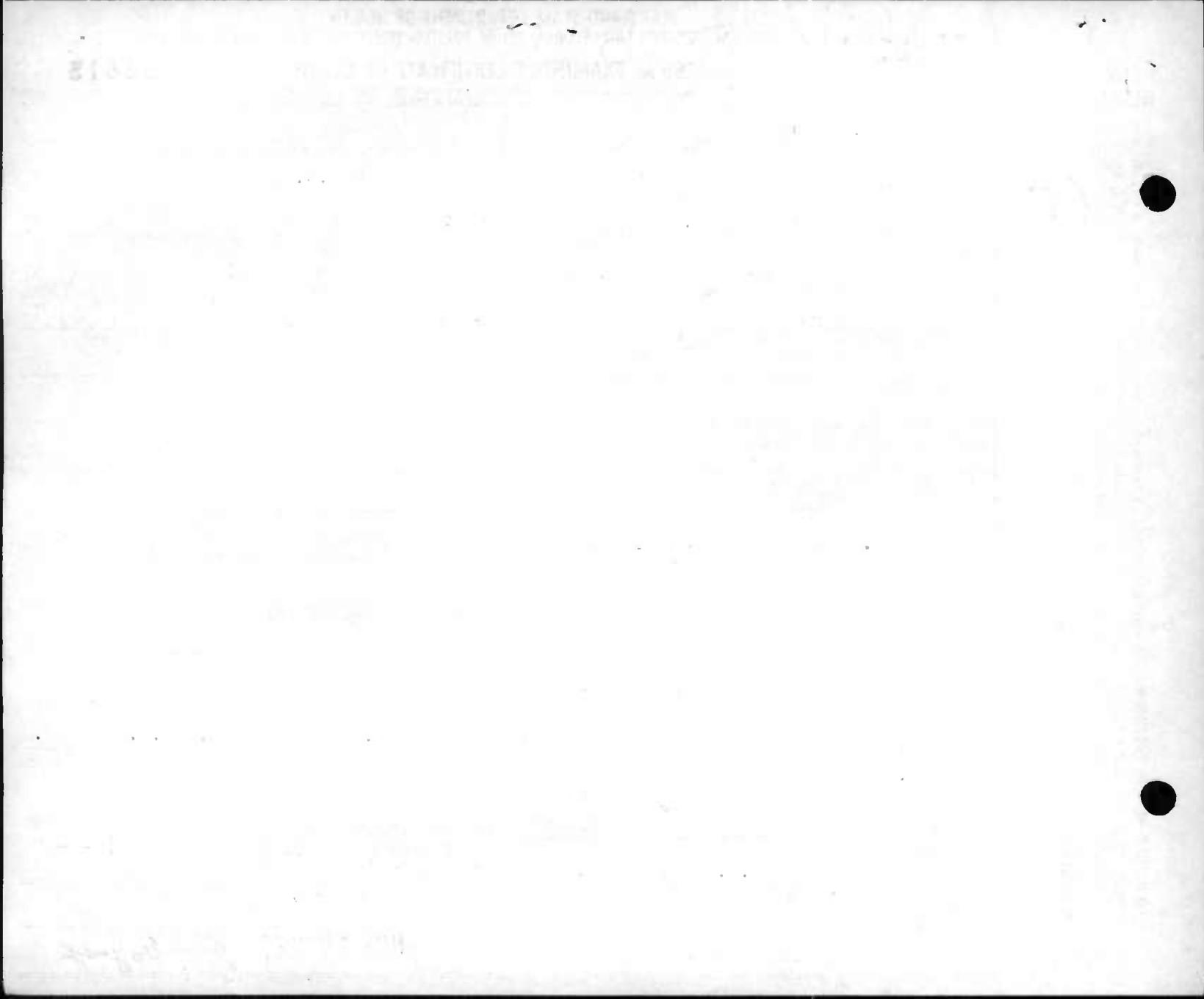
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

~~FOR STATE  
HEALTH DEPT.~~

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>six days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>601 58th Street</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First <b>Tony</b>	Middle <b>Anthony</b>	Last <b>Evans</b>	4. DATE OF DEATH <b>11 4 19 67</b>	Month	Day	Year	
S. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7-23-52</b>	9. AGE (In years last birthday) <b>15</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>983X</b> (b) <b>Depressed skull fracture</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>hit by brick</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11:15 p.m. 10-28 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>711 Eastern Ave.</b>		20f. (City or town) (County) (State) <b>Fairmont Hts., P.G. Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11-6-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-9-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Olivet</b>		23d. LOCATION (City or Town) (County) (State) <b>Wash. D.C.</b>			
24. FUNERAL DIRECTOR <b>Bacon Funeral Home</b>		ADDRESS <b>3447 47th St.</b>		25a. REGD. BY REGISTRAR <b>NOV 10 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



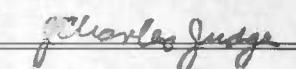
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15816

CERTIFICATE OF DEATH

15822

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Pr. Geo.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Pr. Geo.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 Wks.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>		d. STREET ADDRESS <b>3717 Shephard Street.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pr. Geo. Gem. Hosp.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>EDWARD</b>		First <b>F.</b>	Middle <b>Farley</b>	Lost	4. DATE OF DEATH <b>Nov. 9 1967</b>	Month <b>Nov.</b>	Day <b>9</b>	Year <b>1967</b>		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 2, 1892</b>	9. AGE (In years last birthday) yrs. <b>75</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Engr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. R. R.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>Edward F. Farley Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Ella A. Lott</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>717 07 8512</b>		17. INFORMANT <b>Ariel A. Farley Wife</b>		Address <b>Same as # 2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)										
INTERVAL BETWEEN ONSET AND DEATH										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Suitland</b>		(County) <b>P. G.</b>		(State) <b>Md.</b>
21. I certify that (I) (this hospital) attended the deceased from <b>26 Oct 1967</b> to <b>9 Nov 1967</b> , that (I) (we) last saw the deceased alive on <b>8 Nov 1967</b> , and that death occurred at <b>3:20 PM</b> from <b>Arteriosclerotic cardiovascular disease</b> and on the date stated above.										
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22b. DATE SIGNED <b>11/9/67</b>						
22c. PHYSICIAN'S NAME (Type) <b>Francis Gasch's Sons</b>		22d. ADDRESS <b>Prince George Plaza Hyattsville, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/13/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill</b>		23d. LOCATION (City or Town) <b>Suitland</b>		(County) <b>P. G.</b>		(State) <b>Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>		25b. REGISTRAR'S SIGNATURE 				

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

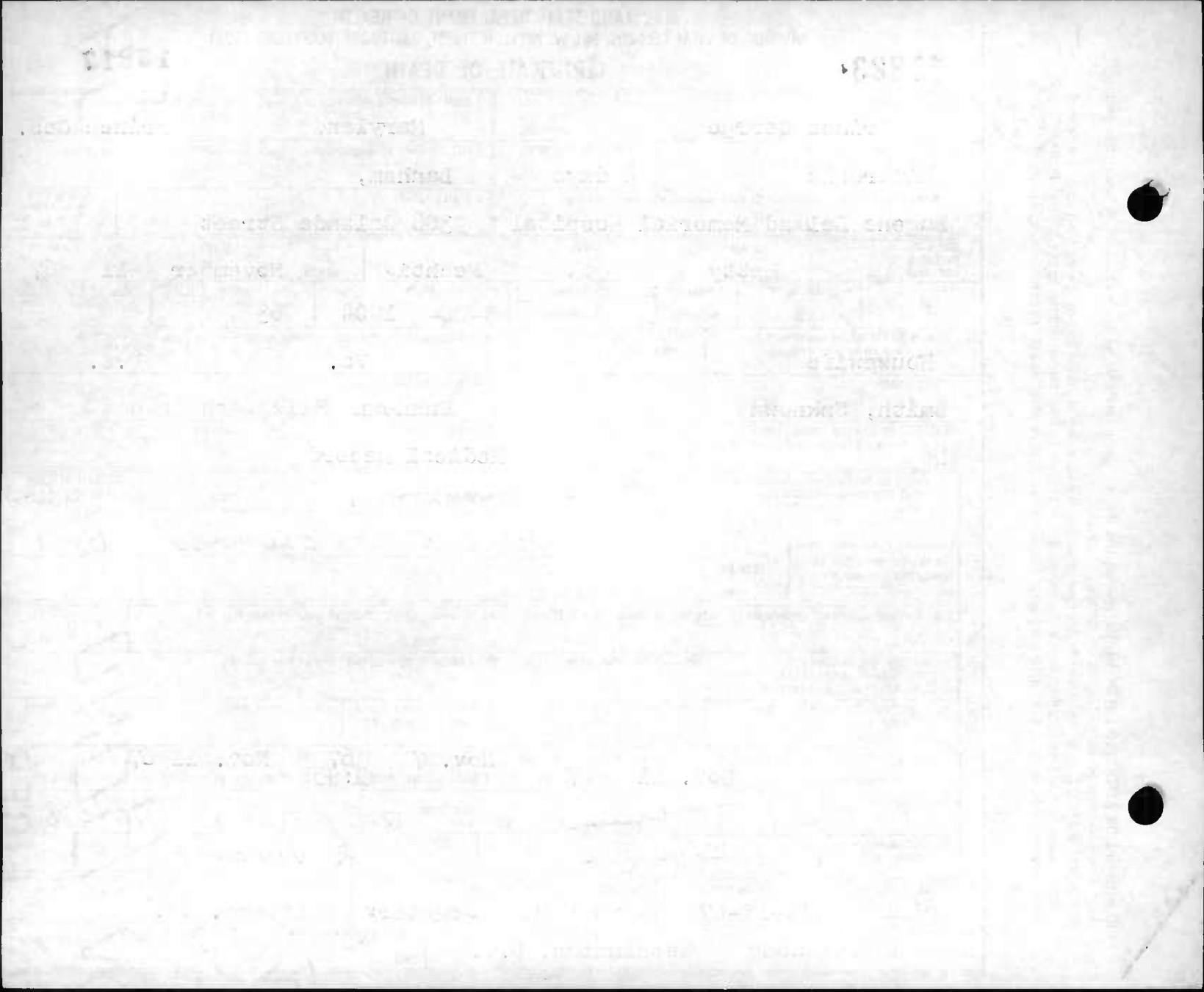
**CERTIFICATE OF DEATH**

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

15823		15817	
<b>1. PLACE OF DEATH</b> a. COUNTY      Prince George      MARYLAND		<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE      Maryland      b. COUNTY      Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 9308 Calanda Street	
<b>3. NAME OF DECEASED (Type or print)</b> First      Middle Betty      S.      Fechtig		<b>4. DATE OF DEATH</b> Month      Doy      Year November      11      19 67	
5. SEX      F	6. COLOR OR RACE      W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24- 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Smith, Unknown		14. MOTHER'S MAIDEN NAME Elizabeth Graham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)      No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Address	
17. INFORMANT Medical Record			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X      DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) lost.      DUE TO (c)			
CARCINOMATOSIS CARCINOMA OF ESOPHAGUS      6 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m.      p.m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town)      (County)      (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 7, 1967, to Nov. 11 1967, that (I) (we) last saw the deceased alive on Nov. 11 1967, and that death occurred at 9:45 AM, from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		M.D.      ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11-12-67
22c. PHYSICIAN'S NAME (Type) C. J. Houmann		22d. ADDRESS RIVERDALE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-15-67	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cedar Hill Cemetery Washington, D.C.		23d. LOCATION (City or Town)      (County)      (State) Suitland, Md.	
24. FUNERAL DIRECTOR Lee Funeral Home		25a. REC'D BY REGISTRAR NUV 14 1967 DATE	
25b. REGISTRAR'S SIGNATURE James George			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15818

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

15824		2		15818	
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>District of Columbia</b> b. COUNTY <b>n/a</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>2hrs. 55mins</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>2634 Woodley Place, NW</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
74					
3. NAME OF DECEASED (Type or print) <b>First Ann</b>		Middle <b>Feeney</b>		4. DATE OF DEATH <b>Nov. 29, 1967</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Feb. 23, 1882</b>		9. AGE (In years last birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Oklahoma</b>	
13. FATHER'S NAME <b>Thomas Archibald</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>573-01-2395D</b>		17. INFORMANT <b>Mrs. Rubyn Bonnington - See Item No. 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		<i>Cardiac insufficiency</i>			
DUE TO		<i>Arteriosclerotic cardiovascular disease 20 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>Nov 15, 1967</b> , to <b>Nov. 29, 1967</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Nov. 29, 1967</b> , and that death occurred at <b>8:15AM</b> , from causes and on the date stated above.		22b. DATE SIGNED			
22a. SIGNATURE <i>Peter Duus</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <b>Peter Duus, M. D.</b>		22d. ADDRESS <b>6124 Central Ave. Capitol Hghts. Md. 20027</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12-2-1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Cedar Hill Crematory</b>	
23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>		23e. REC'D BY REGISTRAR <b>Charles Judge</b>		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		ADDRESS <b>5130 Wisc. Ave. N.W. Wash. D.C.</b>		DATE DEC 4 1967	

81651

PHASE 30 - MARCH 1970

1970

1/10

Standardized column

for the analysis

intensity

percent

Intensity

AT 100% column peak

Top peak: Intensity approximately

versus

versus

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standard

samples

Intensity also

Specimen - standard profile

Specimen

Specimen

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100

Standardized column profile

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**24**  
**4**  
**18**  
**M**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**PRINCE GEORGE COUNTY MEDICAL EXAMINER NOTIFIED AND RELEASED**

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #17 Film #G394 11/15/67 ph**

**CERTIFICATE OF DEATH**

**15819**

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>		d. STREET ADDRESS <b>149 Westway Road</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Stanley</b>		First <b>W.</b>	Middle <b>Fink</b>	Last <b>Fink</b>	4. DATE OF DEATH <b>November 4, 1967</b>	Month <b>November</b>	Day <b>4</b>	Year <b>1967</b>				
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 18, 1913</b>	9. AGE (In years last birthday) <b>54 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>G'vt. Official</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Labor</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Allentown, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>						
13. FATHER'S NAME <b>William Fink</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Dougherty</b>		Address						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>171-05-8379</b>		17. INFORMANT <b>Margaret</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carotid arrest</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Myocardial infarct</b> (c) DUE TO <b>Atherosclerotic heart disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 mo</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Allentown</b>	(County) <b>Penna.</b>	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-3-1967</b> to <b>11/4/67</b> , 1967, that (I) (we) last saw the deceased alive on <b>11-3-1967</b> , and that death occurred at <b>5:17 AM</b> , from causes and on the date stated above.												
22a. SIGNATURE <b>Hans Wodak</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-4-1967</b>				
22c. PHYSICIAN'S NAME (Type) <b>HANS WODAK</b>		22d. ADDRESS <b>GREENBELT PROF. BLDG. GREENBELT</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/7/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Graddview Cemetery</b>		23d. LOCATION (City or Town) <b>Allentown</b>		(County) <b>Penna.</b>		(State)		
24. FUNERAL DIRECTOR <b>F. GASCH'S &amp; Sons</b>		ADDRESS <b>HYATTSVILLE, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						
VR A15 (4) 25M 1/67		DATE <b>NOV 6 1967</b>										



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

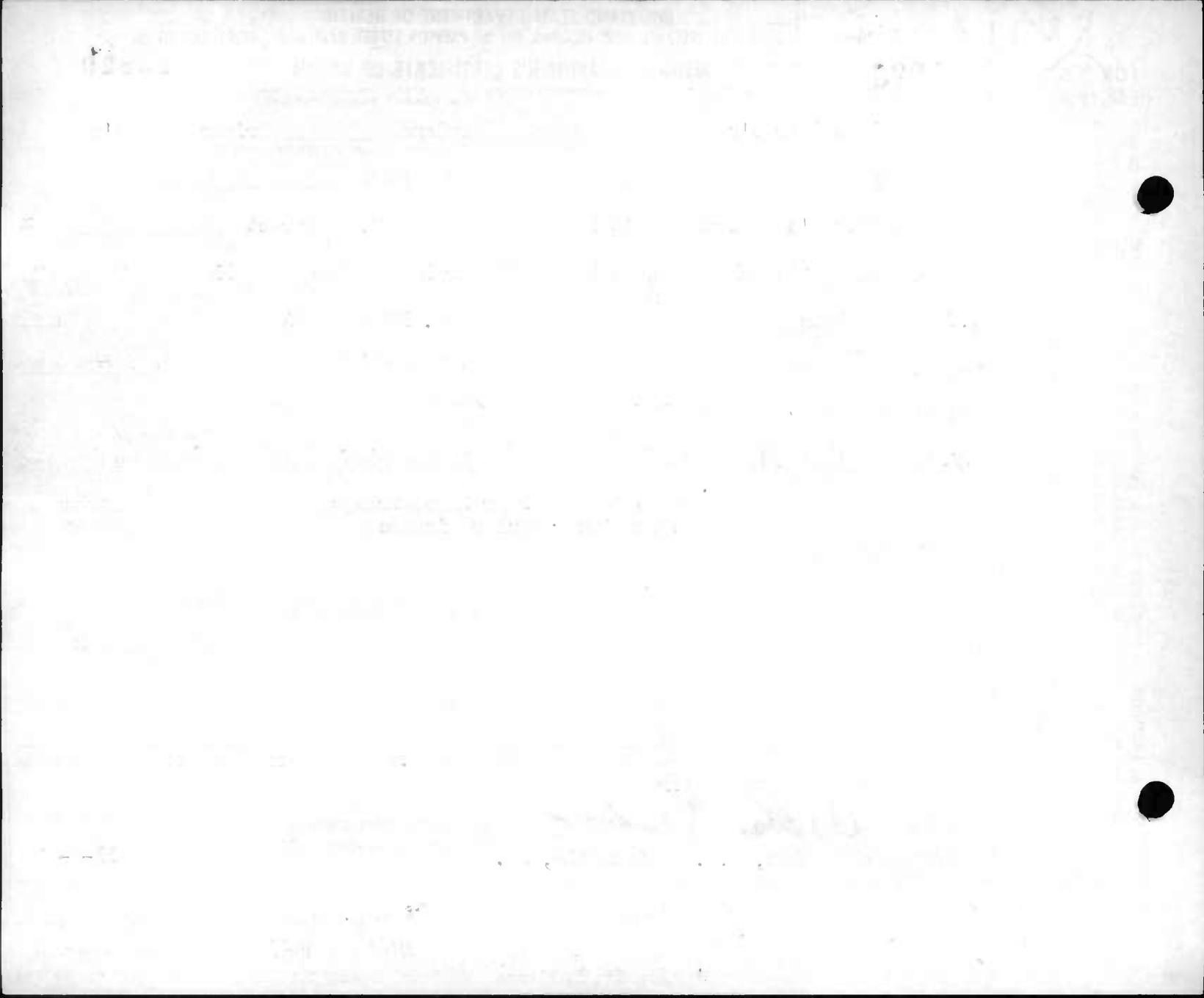
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15826

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15820

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Michael Joseph Fitzgerald</b>			First	Middle	Last
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH <b>29 Aug. 1923</b>	9. AGE (In years last birthday) <b>44 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AUTOMOBILE INSPECTOR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>D.C GOVT.</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>MICHAEL J. FITZGERALD</b>			14. MOTHER'S MAIDEN NAME <b>MARY C. YOUNG</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>			16. SOCIAL SECURITY NO. <b>577-28-7689</b>	17. INFORMANT <b>Virginia Fitzgerald</b>	Address <b>4708 Hamilton St Edmonston, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH minutes		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intra cerebral hemorrhage</b> DUE TO <b>Hypertensive vascular disease</b>			unknown		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Wheaton</b> (County) <b>Maryland</b> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED <b>11-8-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 11 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>GATE OF HEAVEN CEM</b>	23d. LOCATION (City or Town) <b>WHEATON</b> (County) <b>MARYLAND</b> (State)	
24. FUNERAL DIRECTOR <i>W.W. CHAMBERS Co. RIVERDALE, MARYLAND</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>NOV 13 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15821

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15827		15821		
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>16+ days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Annie Elizabeth Fleshman</b>		First      Middle      Last	4. DATE OF DEATH      Month      Day      Year <b>Nov. 10, 1967</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <b>xxx</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/16/85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years lost birthday) yrs. <b>81</b>	
13. FATHER'S NAME <b>Matthew Walsh</b>		11. BIRTHPLACE (County & State, or foreign country) <b>England</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218 09 1102</b>	17. INFORMANT <b>Mary A. Murray Same as #2 (daughter)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b>		INTERVAL BETWEEN ONSET AND DEATH		
154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)		DUE TO <b>perforated bowel</b> DUE TO <b>Carcinoma of rectosigmoid</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.      19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that (I) ( <b>Barry Rosenberg</b> ) attended the deceased from <b>April 1, 1952</b> , to <b>Nov. 10, 1967</b> , that (I) ( <b>Barry Rosenberg</b> ) last saw the deceased alive on <b>Nov. 10, 1967</b> , and that death occurred at <b>2:25 AM</b> , from causes and on the date stated above.				
22a. SIGNATURE <b>Barry Rosenberg</b>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>Barry Rosenberg, M. D.</b>		22d. ADDRESS <b>6501 Landover Rd., Cheverly, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/13/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P. G. Md.</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15822

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>8 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carmody Hills</b>		d. STREET ADDRESS <b>511 732nd Place</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <b>Eldridge</b>	Middle <b>R.</b>	Lost	4. DATE OF DEATH <b>November 11, 1967</b>	Month	Doy	Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>6-16-22</b>	9. AGE (In years lost birthday) <b>45 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Willie Fleshman</b>		14. MOTHER'S MAIDEN NAME <b>Lola M. Rowles</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>235-26-2609</b>		17. INFORMANT <b>Irene Fleshman, 6347 64th Ave., Riverdale, MD.</b>		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5810</b>		HEPATIC COMA		INTERVAL BETWEEN ONSET AND DEATH							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		BLEEDING ESOPHAGEAL VARICES									
DUE TO (c)		CIRRHOSIS OF THE LIVER									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>Nov. 3, 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Waldorf, Charles, Md.</b>		(County) (State)			
21. I certify that <b>(s)</b> (this hospital) attended the deceased from <b>Nov. 3, 1967</b> , to <b>Nov. 11, 1967</b> , that <b>(s)</b> (we) last saw the deceased alive on <b>Nov. 11, 1967</b> , and that death occurred at <b>2:05 p.m.</b> from causes and on the date stated above.								22b. DATE SIGNED <b>11-13-67</b>			
22a. SIGNATURE <i>Ricardo Longoria</i>		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <b>Ricardo Longoria, M. D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-15-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Trinity Memorial</b>		23d. LOCATION (City or Town) <b>Waldorf, Charles, Md.</b>		(County) (State)			
24. FUNERAL DIRECTOR <b>Henry Funeral Home, Waldorf, Md.</b>		ADDRESS <b>Henry Funeral Home, Waldorf, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

2000

1960-1970 1970-1980 1980-1990 1990-2000

electrical conductivity

resistivity

water content

>100 ohm-m

low

dryness

moderate 100-  
Intense Dryness & grassy areas

moderate

dryish

moderate

dryish soil

moderate

moderate

moderate

moderate

moderate

moderate

moderate

moderate

moderate Intense dryness

moderate soil moisture

moderate 100-  
moderate 100-  
moderate 100-

Intense dryness or total aridity  
moderate soil moisture

1  
FOR STATE  
HEALTH DEPT.

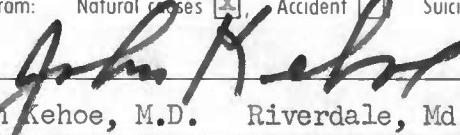
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

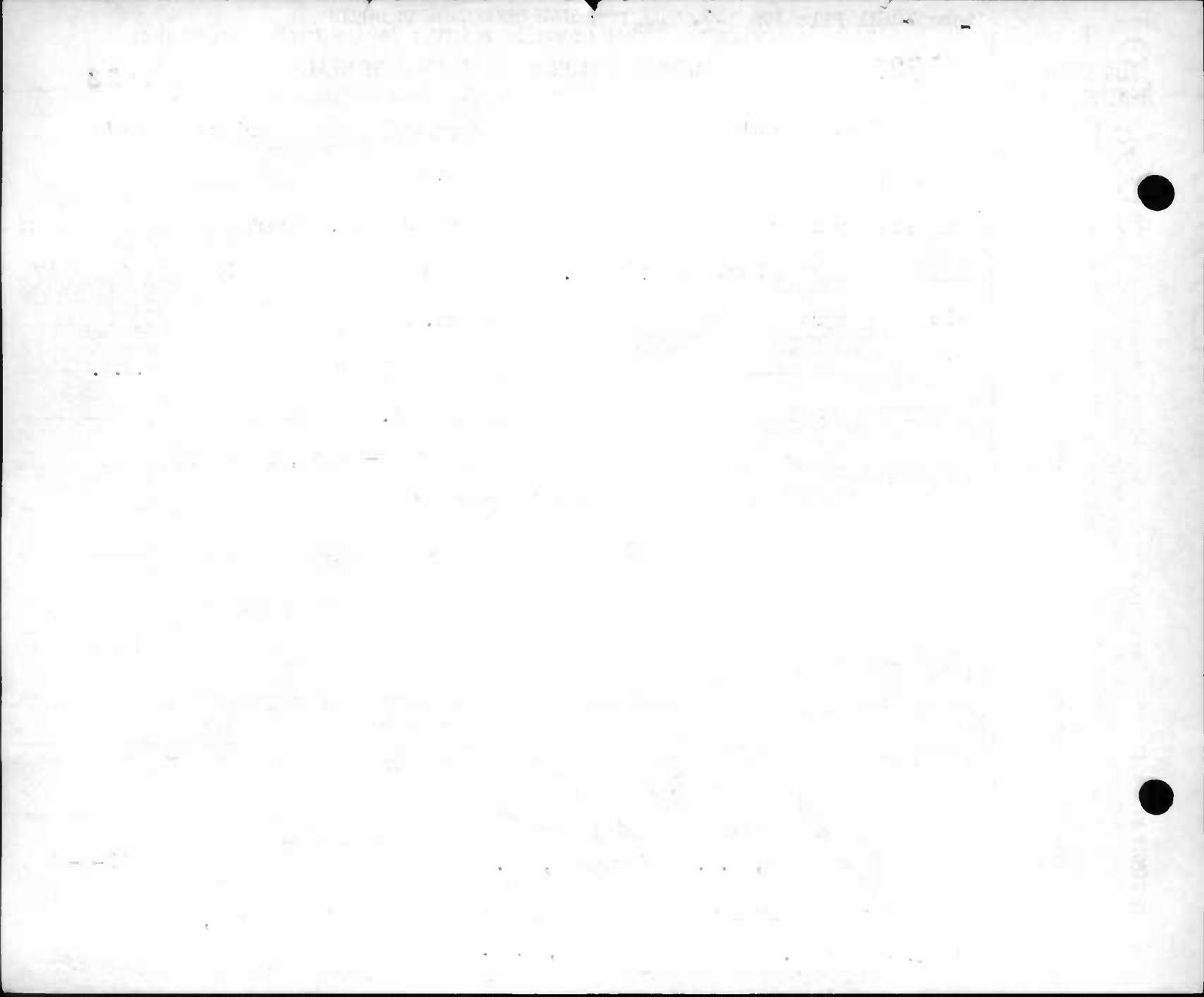
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15823

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15823

PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA		c. LENGTH OF STAY IN 1b <b>Bowie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>Box 204 8th Street</b>	
3. NAME OF DECEASED (Type or print) <b>Robert (Quinton T.) Foote</b>		First <b>Robert</b>	Middle <b>(Quinton T.)</b>
4. DATE OF DEATH <b>11 7 19 67</b>	Month <b>11</b>	Day <b>7</b>	Year <b>19 67</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>25 Oct. 1967</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLIFTON FOOTE</b>		14. MOTHER'S MAIDEN NAME <b>EMMA I. THOMAS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT <b>CLIFTON FOOTE - BOWIE, MARYLAND</b>
Address			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>7630</b> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Riverdale, Md.</b>
20f. (City or town) <b>Riverdale</b>		(County) <b>Md.</b>	(State) <b>Maryland</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
22. DATE SIGNED <b>11-9-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-11-67</b>	23c. NAME OF CEMETERY OR CREMATORIALY <b>Harmony Memorial Park</b>
23d. LOCATION (City or Town) <b>Prince George, Maryland</b>		(County) <b>Maryland</b>	(State) <b>Maryland</b>
24. FUNERAL DIRECTOR <b>John T. Rhines Co.</b>		ADDRESS <b>3015 12th Street, N. E.</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>
			25b. REGISTRAR'S SIGNATURE
			DATE <b>NOV 13 1967</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

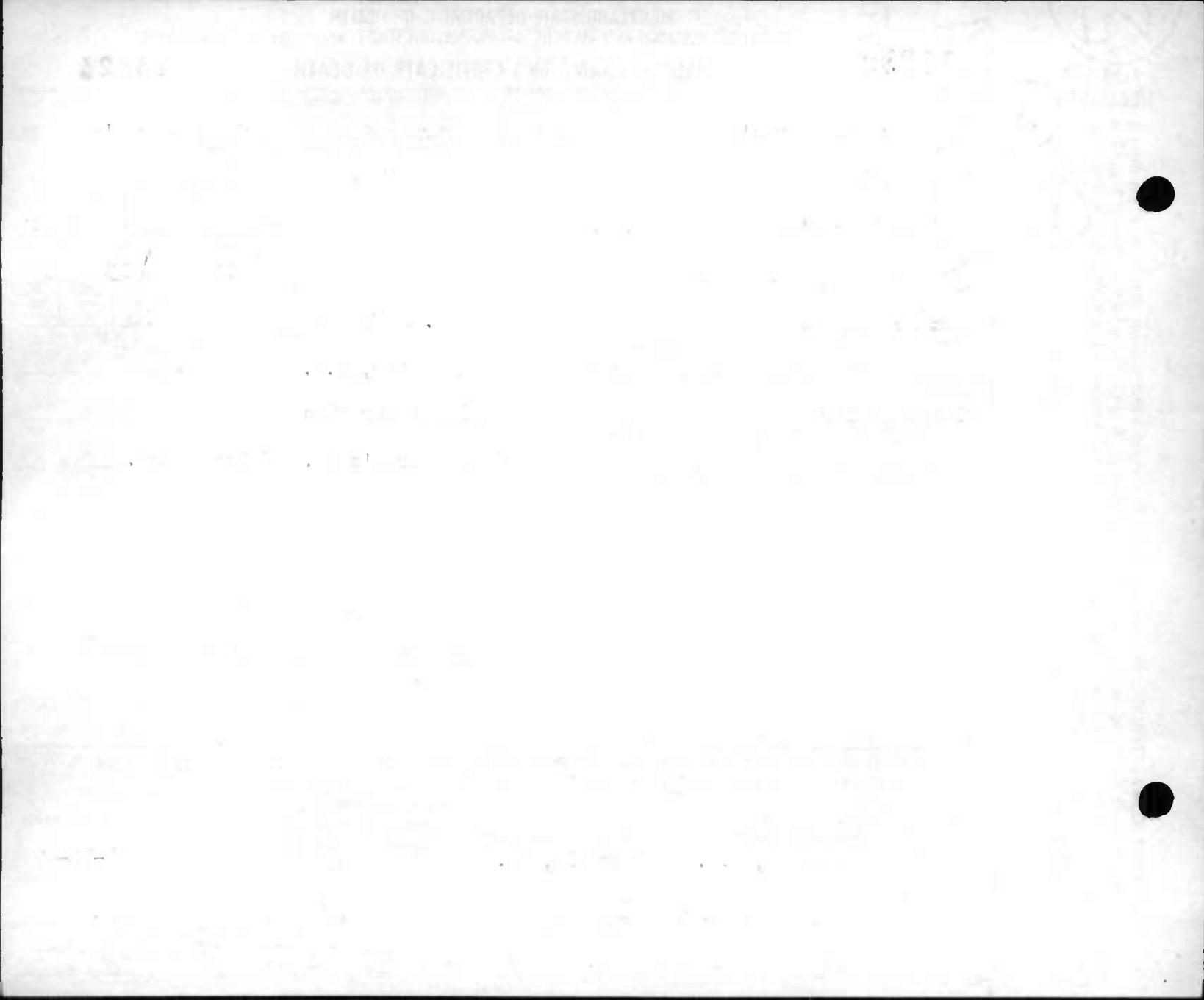
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15830

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15824

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN 1b <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Branchville</b>	d. STREET ADDRESS <b>4709 Greenbelt Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Alexandra</b>	Middle <b>Forsythe</b>	Last <b>11 13 19 67</b>	
4. DATE OF DEATH	Month	Day	Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Oct. 1967</b>	
9. AGE (In years last birthday) Yrs. <b>18</b>		10. IF UNDER 1 YEAR Months <b>18</b> Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Claude Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Elexis Forsythe</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		
17. INFORMANT		Address <b>Prince George's Co. Welfare Board.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7952</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>SDIT</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-16-67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Savage Cem</b>	23d. LOCATION (City or Town) (County) (State) <b>Savage Md.</b>
24. FUNERAL DIRECTOR <b>DeWitt Danaean Laurel Md</b>		ADDRESS <b>77032945</b>	25a. REC'D BY REGISTRAR DATE <b>NOV 22 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



**1**  
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

15831						15825	
1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LANHAM</i>		c. LENGTH OF STAY IN lb <i>13 HRS.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>AVONDALE</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>MAGNOLIA GARDENS NURS. HOME</i>		d. STREET ADDRESS <i>4627 EASTERN AVE.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ROBERT J. FREEMAN</i>		First	Middle	Last	4. DATE OF DEATH <i>Nov. 19 1967</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>CAU.</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>Aug. 14, 1922</i>	9. AGE (In years last birthday) yrs. <i>45</i>	IF UNDER 1 YEAR Months <i>N.C.</i>	IF UNDER 24 HRS. Days Hours Min. <i>U.S.</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brick Mason</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (County & State, or foreign country) <i>N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Leonard Freeman</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Jones</i>		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes</i> <i>WWII</i>		16. SOCIAL SECURITY NO. <i>249-18-4698</i>		17. INFORMANT <i>Mrs. Vivian C. Freeman (above ad-</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1939</i> DUE TO Conditions, if any, which gave rise to immediate cause (a) } stating the underlying cause last. } (b) DUE TO (c)							
(Wife) (dress) <i>Cardiorespiratory failure</i> <i>Meninges</i> <i>Glioblastoma Multiforme</i> <i>2 months</i>							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8/8/67</i> to <i>19 NOV 1967</i> , that (I) (we) last saw the deceased alive on <i>18 NOV 1967</i> and that death occurred at <i>7:30 AM</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>D. Paul Devere</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>19 NOV 67</i>				
22c. PHYSICIAN'S NAME (Type) <i>Paul A Devere MD</i>		22d. ADDRESS <i>3415 Hamilton St Hyattsville</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/22/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. View Baptist Ch. Cem. - Rutherford, N.C.</i>	23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Nalley's Funeral Home Inc.</i>		ADDRESS <i>Mt. Rainier, Maryland</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 22 1967</i>	25b. REGISTRAR'S SIGNATURE <i>James Judge</i>			

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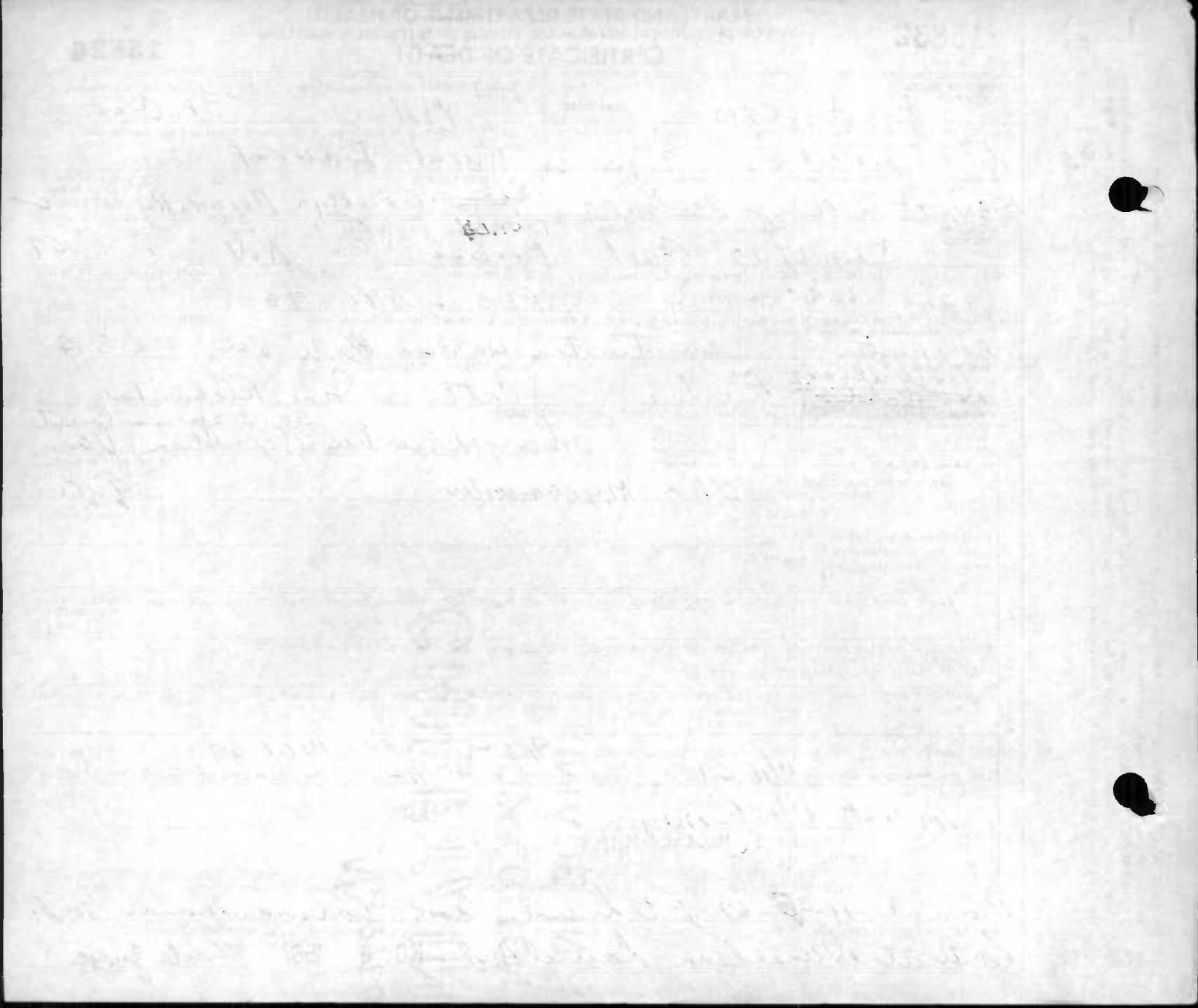
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15826

1. PLACE OF DEATH a. COUNTY <i>Pr. George</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Laurel</i>		c. LENGTH OF STAY IN 1b <i>9 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1510-15 Brooklyn Brdg Rd</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Laurel</i>	
3. NAME OF DECEASED (Type or print) <i>CLAUDIUS Gail Furbee</i>		4. DATE OF DEATH Month <i>NOV</i> Day <i>1</i> Year <i>1967</i>	
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>FEB 16 1891</i>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>construction</i>	
10c. FATHER'S NAME <i>William Furbee</i>		11. BIRTHPLACE (State or foreign country) <i>Harrison Co. W. Va</i>	
13. MOTHER'S NAME <i>Catherine Jane Richards</i>		14. MOTHER'S MAIDEN NAME <i>Danned Furbee Alephathia, Va.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Chr. Myreaditor</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4222</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>52 1/4 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/22</i> to <i>11/1/67</i> , that (I) (we) last saw the deceased alive on <i>11/1/67</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT S. McCENEY, M.D.</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE OF DEATH <i>11-30-67</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Dannedon, Laurel Md.</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>1st Peninsula Cem</i>	
ADDRESS <i>402 Main St.</i>		23d. LOCATION (City, town, or county) <i>Calvert Narrows Md.</i>	
25a. REC'D BY REGISTRAR <i>NOV 6 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>	

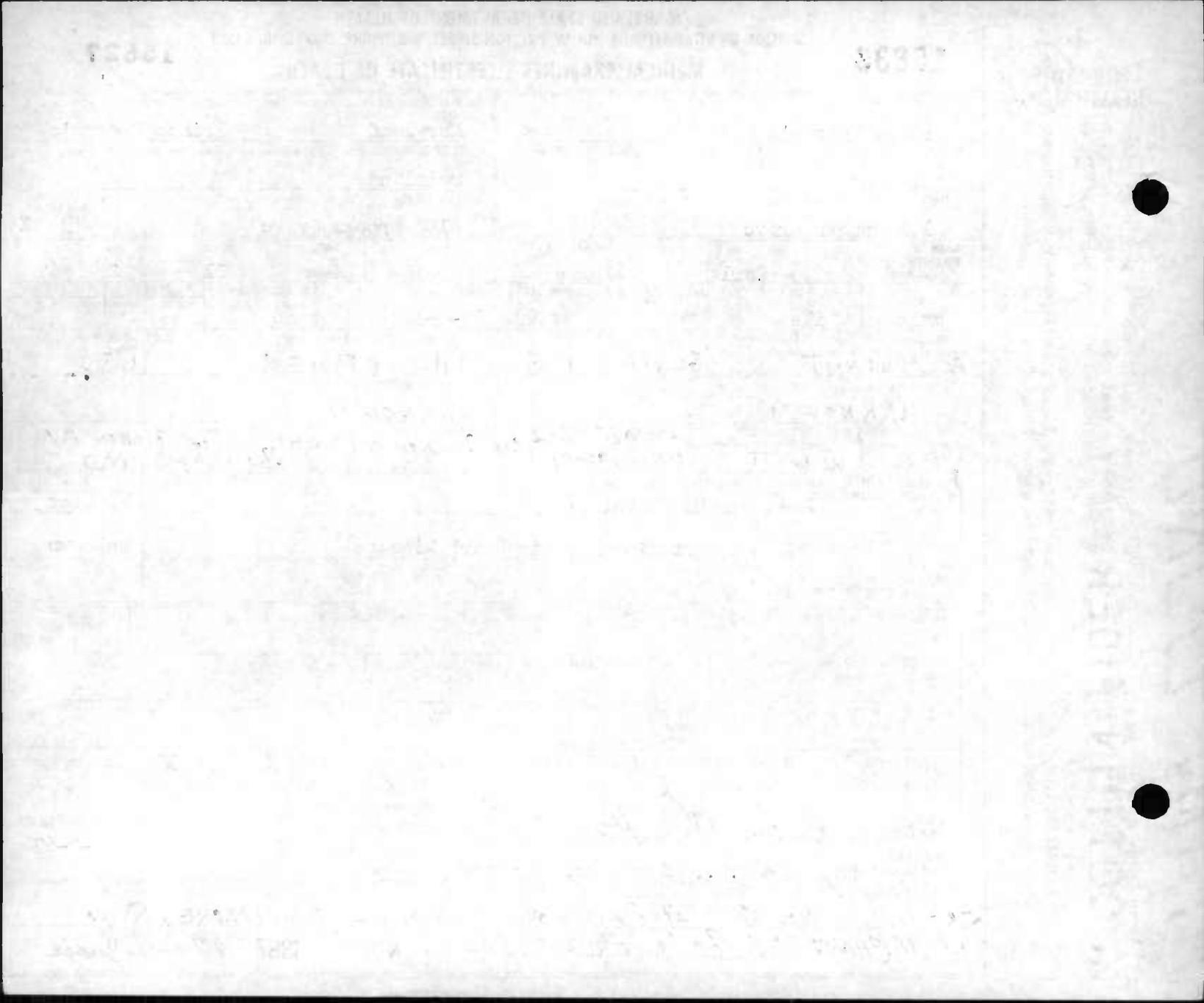


FOR STATE  
HEALTH DEPT.

If any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to  
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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												MEDICAL EXAMINER'S CERTIFICATE OF DEATH			15827		
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>						b. COUNTY <b>Prince George's</b>											
c. LENGTH OF STAY IN lb						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>						16 - 1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4101 Brooks Drive</b>						d. STREET ADDRESS <b>4101 Brooks Drive</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Carl</b>	Middle <b>Alegre</b>	Lost	4. DATE OF DEATH	Month <b>11</b>	Day <b>2</b>	Year <b>1967</b>									
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-4-10</b>			9. AGE (In years last birthday) <b>56 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>		11. IF UNDER 24 HRS. Days <b>0</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>GENACCT. U.S.</b>			11. BIRTHPLACE (State or foreign country) <b>PHILIPPINES</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>								
13. FATHER'S NAME <b>UNKNOWN</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b> <b>W.W. II</b>			16. SOCIAL SECURITY NO. <b>103-05-7482</b>			17. INFORMANT <b>KIR.GORDON B. PRACHT</b> , Address <b>4795 HURON AV. SUITLAND, MD</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>4200</b>			DUE TO						INTERVAL BETWEEN ONSET AND DEATH minutes.								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic Heart Disease</b>									unknown								
(c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)														
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.      19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22. DATE SIGNED <b>11-3-67</b>					
ACTUAL SIGNATURE <i>John Kehoe</i>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Address (Street, city, town, or county)																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>Nov 8 1967</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>BALTIMORE NATIONAL</b>			23d. LOCATION (City or Town) <b>BALTIMORE, MD.</b>								
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS - CO RIVERDALE, MD</b>			ADDRESS			25a. RECD BY REGISTRAR <b>NOV 7 1967</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

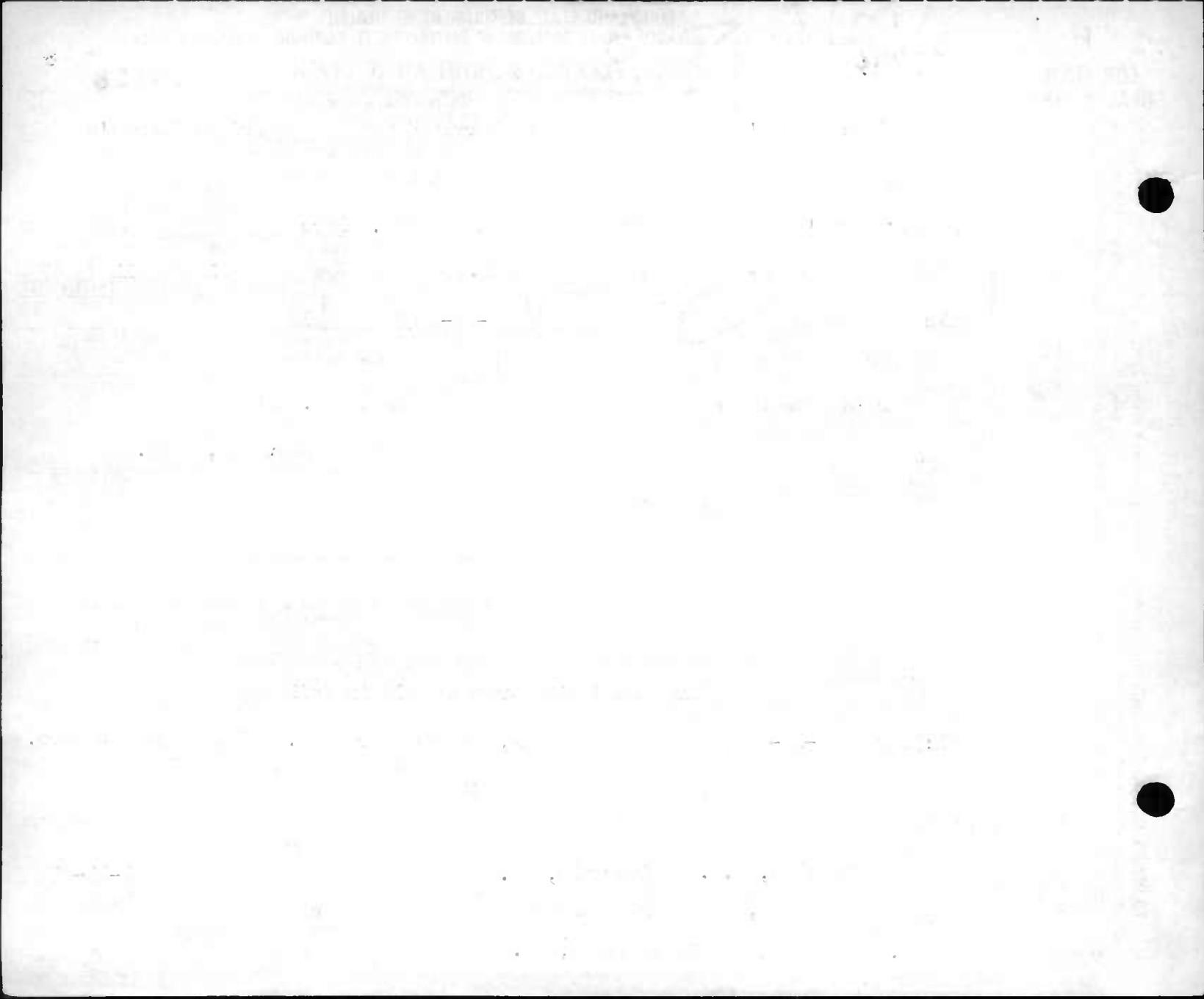
15828

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15834								
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kentland</b>		16 - 1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>2830 75th. Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Kenneth Lee Genthner</b>		First	Middle	Lost	4. DATE OF DEATH <b>11 11 1967</b>	Month	Doy	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH <b>6-10-1949</b>	9. AGE (In years lost birthday) <b>18 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington D C</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Erwin P Genthner</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy L. Smith</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Erwin P Gunthner</b>		Address <b>Kentland, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> 974X DUE TO <b>Hanging</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause lost. (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hung self with trouser belt in jail</b>						
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>11:50pm 11-10-1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cell, Prince George Co. Jail, Upper Marlboro.</b>		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11-13-67</b>		
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 14, 1967</b>		23c. NAME OF CEMETERY OR Crematory <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 17 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

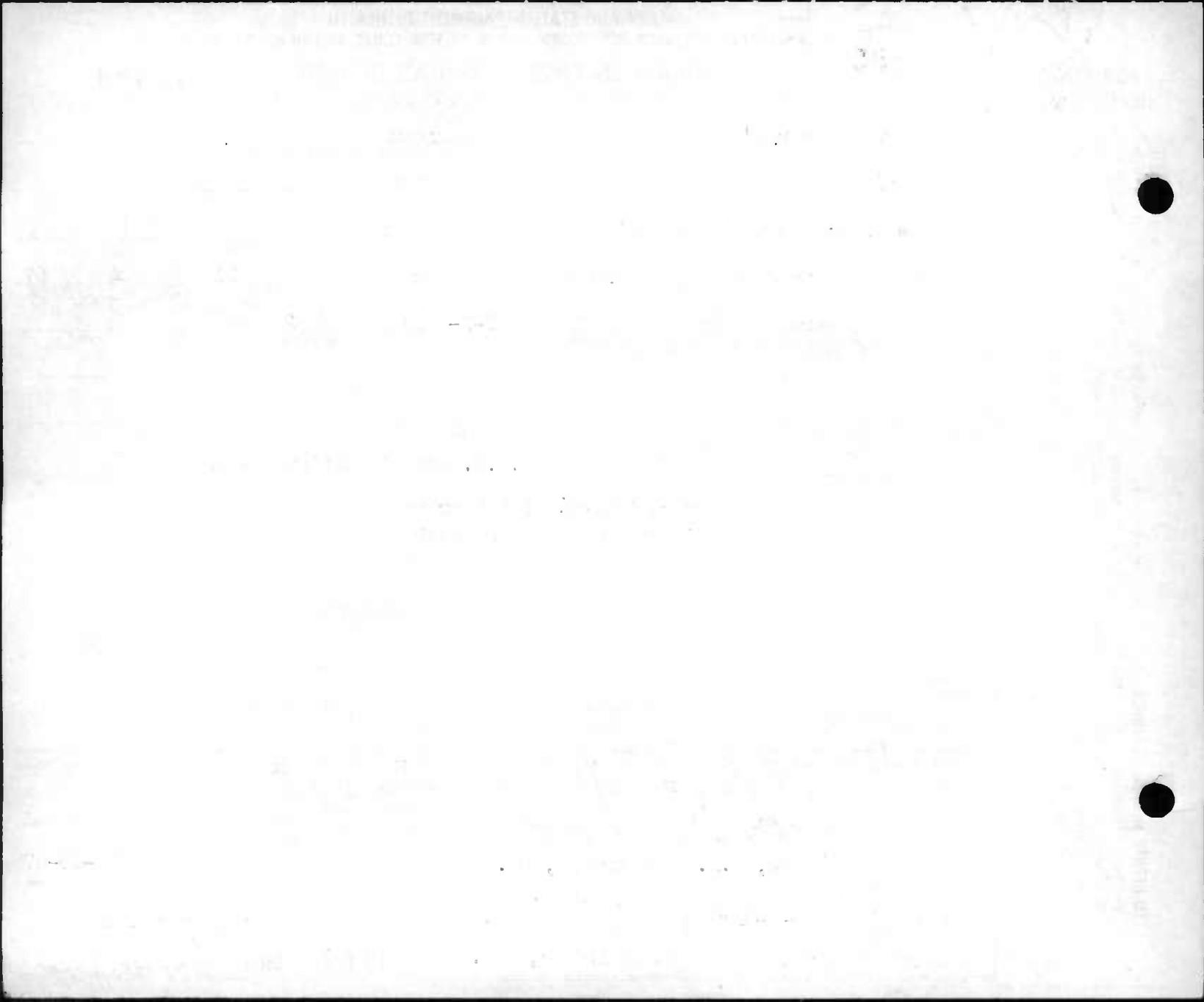
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15835

17490

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Unknown</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN lb <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Unknown</b>	d. STREET ADDRESS <b>Unknown</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thaddeus Spencer Gibbs</b>	First <b>Thaddeus</b>	Middle <b>Spencer</b>	Last <b>Gibbs</b>
S. SEX <b>Male</b>	6. COLDR OR RACE <b>Negro</b>	7. MARRIED WIDDWED <input type="checkbox"/> DIVORCEO <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-1915</b>
9. AGE (In years lost birthday) <b>52 yrs.</b>		10. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>None</b>
12. CITIZEN OF WHAT COUNTRY? <b>None</b>		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY ND.		17. INFORMANT <b>F.B.I. Identification #716349B</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5411</b> IMMEDIATE CAUSE (o) <b>Gastro intestinal hemorrhage</b> DUE TO <b>Perforating duodenal ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>
20f. (City or town) <b>None</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>12-6-1967</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>University Hospital Anatomy Department</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Nalley Funeral Home</b>		ADDRESS <b>Mt Rainier, Md.</b>	
25a. RECEIVED BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

<b>CERTIFICATE OF DEATH</b>						15829		
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>1+1/2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>409 Lyndon Ave., Oak crest</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Lester E. Gibson</b>		First	Middle	Lost	4. DATE OF DEATH <b>Nov. 27, 1967</b>	Month	Doy	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/30/18</b>	9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ernest Gibson</b>			14. MOTHER'S MAIDEN NAME <b>Lavenia Mack</b>			Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT				
					<b>Viola Gibson 118 Cissell Ave. Laurel, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>330X</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ruptured Berry aneurysm, Circle of Willis</b>								
DUE TO (c) <b>Bronchopneumonia, bilateral</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>(he)</b> (this hospital) attended the deceased from <b>Nov. 26, 1967</b> , to <b>Nov. 27, 1967</b> , that <b>(we)</b> last saw the deceased alive on <b>Nov. 27, 1967</b> , and that death occurred at <b>3:50 P.M.</b> from causes and on the date stated above.								
22a. SIGNATURE <i>Arnold G. Brody</i>		22b. DATE SIGNED <b>Nov. 28, 1967</b>						
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>12-1-67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <i>George R. Snowden</i>		ADDRESS <i>Rockville</i>		25a. REC'D BY REGISTRAR <b>DEC 6 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judd</i>		

1970-10-20 10:00 AM - 10:30 AM

83067

83068

1000 hours

1000 hrs

1000 hrs

Initial

Final value

Final value

1000 hrs, 1000 hrs

1000 hrs, 1000 hrs

Initial

Final

1000 hrs

1000 hrs

Initial, 1000 hrs, 1000 hrs

1000 hrs, 1000 hrs

1000 hrs, 1000 hrs, 1000 hrs

Initial, Final

750

Final, 1000 hrs, 1000 hrs

1000 hrs, 1000 hrs

Initial, 1000 hrs, 1000 hrs

1000 hrs, 1000 hrs

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15837

15830

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>			d. STREET ADDRESS <b>4709 Guilford Rd</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>C</b>	Middle <b>Gillis</b>	Lost	4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>1967</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/12/89</b>	9. AGE (In years lost birthday) <b>78 77 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John C. Power</b>			14. MOTHER'S MAIDEN NAME <b>Mulligan Mary Mulligan</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-10-6715</b>		17. INFORMANT <b>4709 Guilford Rd</b> Address <b>Gillis, Murdock College Park, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1750</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMATOSIS</b> DUE TO (c) <b>CA OF OVARY (RT.)</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-31</b> , 1967, to <b>11-6</b> , 1967, that (I) (we) last saw the deceased alive on <b>1967</b> , and that death occurred at <b>3 PM</b> , from causes and on the date stated above.		20f. (City or town) <b>(County)</b> (State)			
22a. SIGNATURE <b>(-). Horneau</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11-6-67</b>		
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Rockville Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville, Md.</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 10 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TERET

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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15833		15831													
1. PLACE OF DEATH o. COUNTY <b>Prince Georges</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>					b. COUNTY <b>Holmes</b> <b>Ann Arundel</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessup</b>			d. STREET ADDRESS <b>Holiday Mobile Estates B-1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>					4. DATE OF DEATH <b>November 15, 1967</b>					Month Day Year					
3. NAME OF DECEASED (Type or print)		First <b>Hazel</b>	Middle <b>B.</b>	Last <b>Gilson</b>	5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-11-98</b>	9. AGE (In years at birthday) <b>69</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>	12. Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Penn.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George William Ali Baker</b>					14. MOTHER'S MAIDEN NAME <b>Enlow, Barbara</b>					Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>162-11-6945</b>			17. INFORMANT <b>Daughters/Medical Record</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTERCAPILLARY GLOMERULO SCLEROSIS</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) <b>DIABETES MELLITUS</b> stating the underlying cause lost. (c)										INTERVAL BETWEEN ONSET AND DEATH <b>30 YR.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Laurel</b>		(County) <b>Md.</b>		(State) <b>Md.</b>					
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from causes and on the date stated above.										22b. DATE SIGNED <b>15 Nov 67</b>					
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>612 Main Street, Laurel, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 18, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Lafayette Mem. Park</b>			23d. LOCATION (City or Town) <b>Briar Hill, Pa.</b>			(County) <b>Pa.</b>					
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm</b>		4308 Suitland Rd.		25a. REC'D BY REGISTRAR <b>Charles Judge</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			(Store)					
Robert E. Wilhelm		Suitland, Md.		DATE <b>NOV 20 1967</b>											

15482

BIRDS

1961-62  
VOL 1  
CONTINUED

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 4 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15839

15832

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D. C.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN lb <b>6mos., 2wks.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>			d. STREET ADDRESS <b>129 Tenn. Ave., N. E.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>James</b>		First <b>James</b>	Middle <b>--</b>	Last <b>Glover, Jr.</b>	4. DATE OF DEATH Month <b>11</b> Day <b>1</b> Year <b>1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> separated <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <b>5/24/1917</b>	9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>0</b> Hours <b>0</b> Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown - unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>James Glover, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Rachael M. Smith</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>248-12-5369</b>	17. INFORMANT <b>Decedent</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma of right lung with metastases</b> 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ } DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Pulmonary tuberculosis; diabetes mellitus; rheumatoid arthritis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/17/1967</b> to <b>11/1/1967</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>11/1/1967</b> , and that death occurred at <b>9:45 AM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>11/1/67</b>			
22a. SIGNATURE <i>Moe Weiss</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>			
23a. BURIAL REMOVAL (Specify)		23b. DATE THEREOF <b>10-17-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>HARMONY MEMORIAL</b>	23d. LOCATION (City or Town) (County) (State) <b>7601-SHERIFFD LANDOR MD</b>	
24. FUNERAL DIRECTOR <i>James T. Sutton</i>		ADDRESS <b>2718-12th N.E.</b>	25a. REC'D BY REGISTRAR <b>NOV 6 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15840

15833

## CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>Prince Geo.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <i>Washington DC.</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Forestville, Md.</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, DC</i>		d. STREET ADDRESS <i>944 Southern Ave. S.E.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Regent Rehabilitation Center</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Robert</i>		First	Middle	Lost	4. DATE OF DEATH Month <i>11 - 18</i>	Month	Doy Year <i>1967</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>CAU.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>7-8-1893</i>	9. AGE (In years lost birthday) <i>74 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours Min. <i>0</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retd - Guard D.C. Jail</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (County & State, or foreign country) <i>La Plata, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Townly Goldsmith</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Welch</i>		Address <i>Pina B. Goldsmith - Same as #2</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>COMA</i>	
296 X		DUE TO <i>CEREBRAL HEMORRHAGE</i>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.		(b) DUE TO <i>THROMBOCYTOPENIA,</i>		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>PANCYTOPENIA, CEREBROVASCULAR INSUFFICIENCY, CHRONIC OBSTRUCTIVE LUNG DISEASE</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State) <i>None</i>		21. I certify that (I) (this hospital) attended the deceased from <i>10-18-1967</i> to <i>11-18-1967</i> that (I) (we) last saw the deceased alive on <i>11-17-1967</i> , and that death occurred at <i>10:45 PM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>11-19-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>OLIVER B. BOND</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <i>6872 LUMBERDALE RD</i> <i>LANHAM MARYLAND 20801</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-21-1967</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		ADDRESS <i>1661-Good Hope Rd SE Wash DC</i>		25a. REC'D. BY REGISTRAR <i>NOV 20 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) 20 M 1/68				DATE			

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1938-39 STATION

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

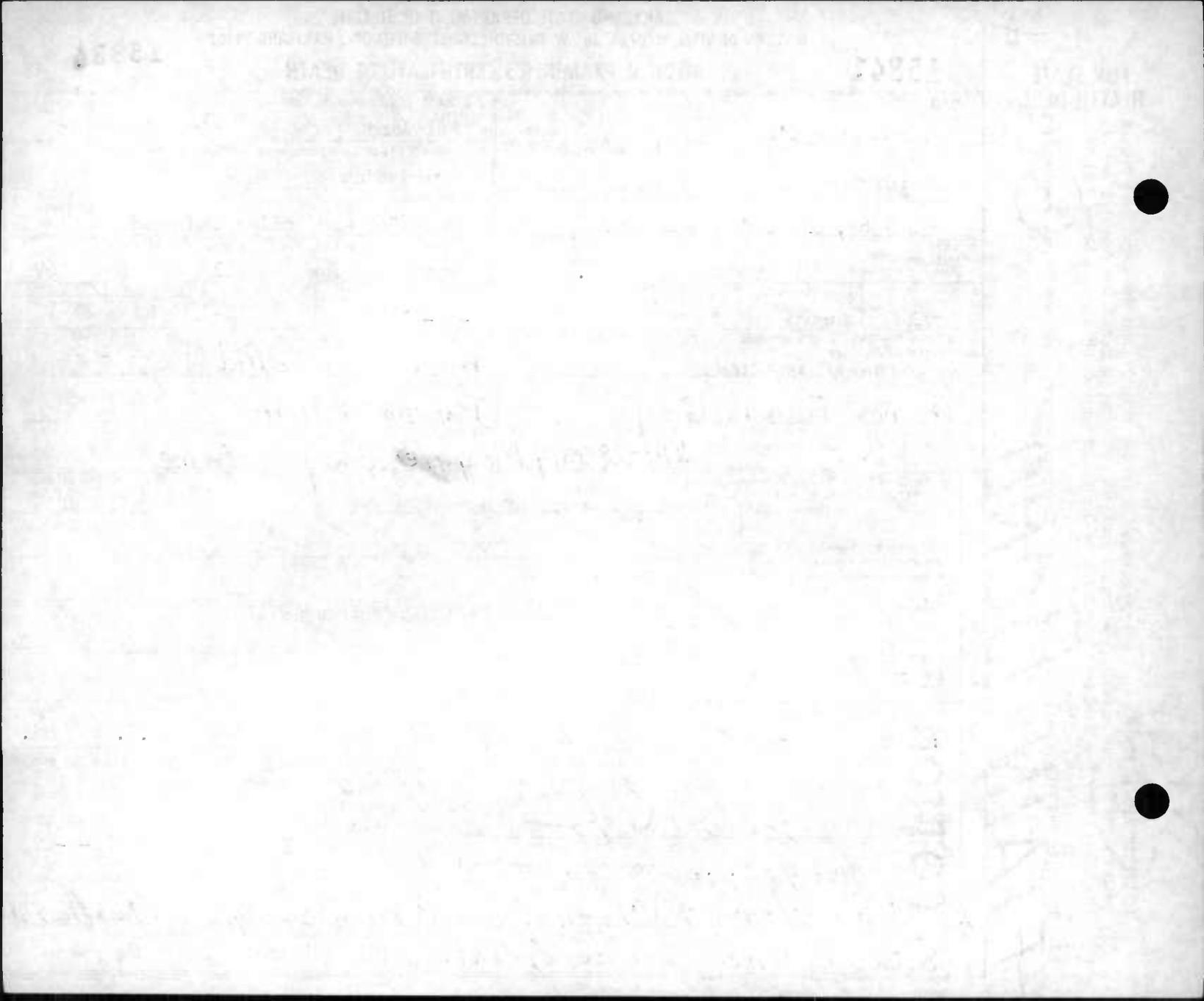
15834

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>		c. LENGTH OF STAY IN 1b 		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box #369, Old Indianhead Road</b>						d. STREET ADDRESS <b>Box #369 Old Indianhead Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas</b>		First <b>I.</b>	Middle <b>Gray</b>	Lost <b>11</b>	4. DATE OF DEATH <b>4 19 67</b>	Month <b>11</b>	Doy <b>4</b>	Year <b>1967</b>			
S. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>2-18-31</b>	9. AGE (In years lost birthday) <b>36 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	Hours <b>0</b>	Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Government Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <b>Prince Geo's. Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>					
13. FATHER'S NAME <b>Thomas Francis Gray</b>		14. MOTHER'S MAIDEN NAME <b>Rosetta Edelin</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-28-8814</b>		17. INFORMANT <b>Maggie Gray</b>		Address <b>Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>981X</b>		DUE TO <b>Gunshot wound of head</b>								INTERVAL BETWEEN ONSET AND DEATH minutes <b>0</b>	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) 		DUE TO 									
(c) 											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>shot by assailant</b>									
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>1:50pm p.m. 11-4 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>driveway of home</b>		20f. (City or town) <b>Brandywine</b>		(County) <b>P.G.</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED <b>11-6-67</b>	
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>John Kehoe M.D., Riverdale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-9-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Church of God Cem. Brandywine, Prince Geo's, Md.</b>		23d. LOCATION (City or Town) <b>Brandywine, Prince Geo's, Md.</b>		(County) <b>Prince George's</b>		(State) <b>Maryland</b>	
24. FUNERAL DIRECTOR <b>Martell Adams Aquasco, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>Charles J. Gray</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Gray</b>					
				DATE NOV 14 1967							

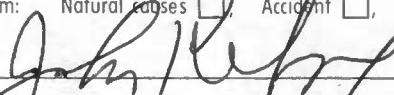


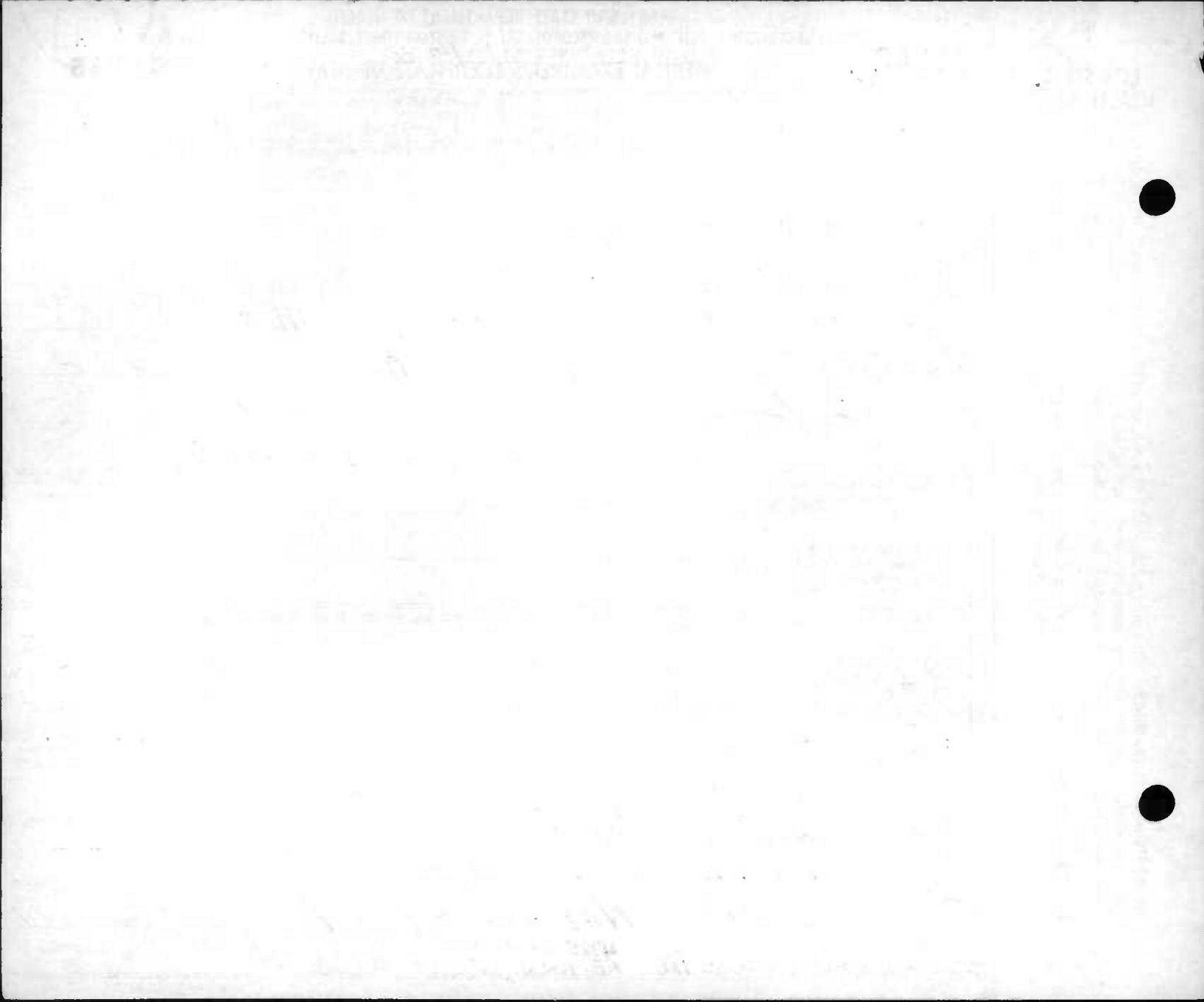
FOR STATE  
HEALTH DEPT.

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15842  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item#9 Film G395 11/21/67 kk  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
16-1  
15835

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Deanwood Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1302 51st Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Naomi	Middle E.	Last Greenleaf	
4. DATE OF DEATH 11 10 19 67	Month	Day	Year	
S. SEX female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	8. DATE OF BIRTH 4-9-18	
NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 46 49 rs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10b. KIND OF BUSINESS OR INDUSTRY Beauty Shop		
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Boswell Gates		14. MOTHER'S MAIDEN NAME Carrie Gibson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		
17. INFORMANT Edith Barber - neice		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X Gunshot wound of head DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) shot during altercation		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:25am p.m. 11-10 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) KITCHEN of home	20f. (City or town) (County) (State) Deanwood Park, P.G. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-14-67	23c. NAME OF CEMETERY OR CREMATORIAL Nat. Harmony	23d. LOCATION (City or Town) (County) (State) Highland Park Md	
24. FUNERAL DIRECTOR H.S. WASHINGTON & SONS INC.	ADDRESS 4925 Deane Ave NE. WASH. D.C.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE DATE NOV 16 1967	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15843

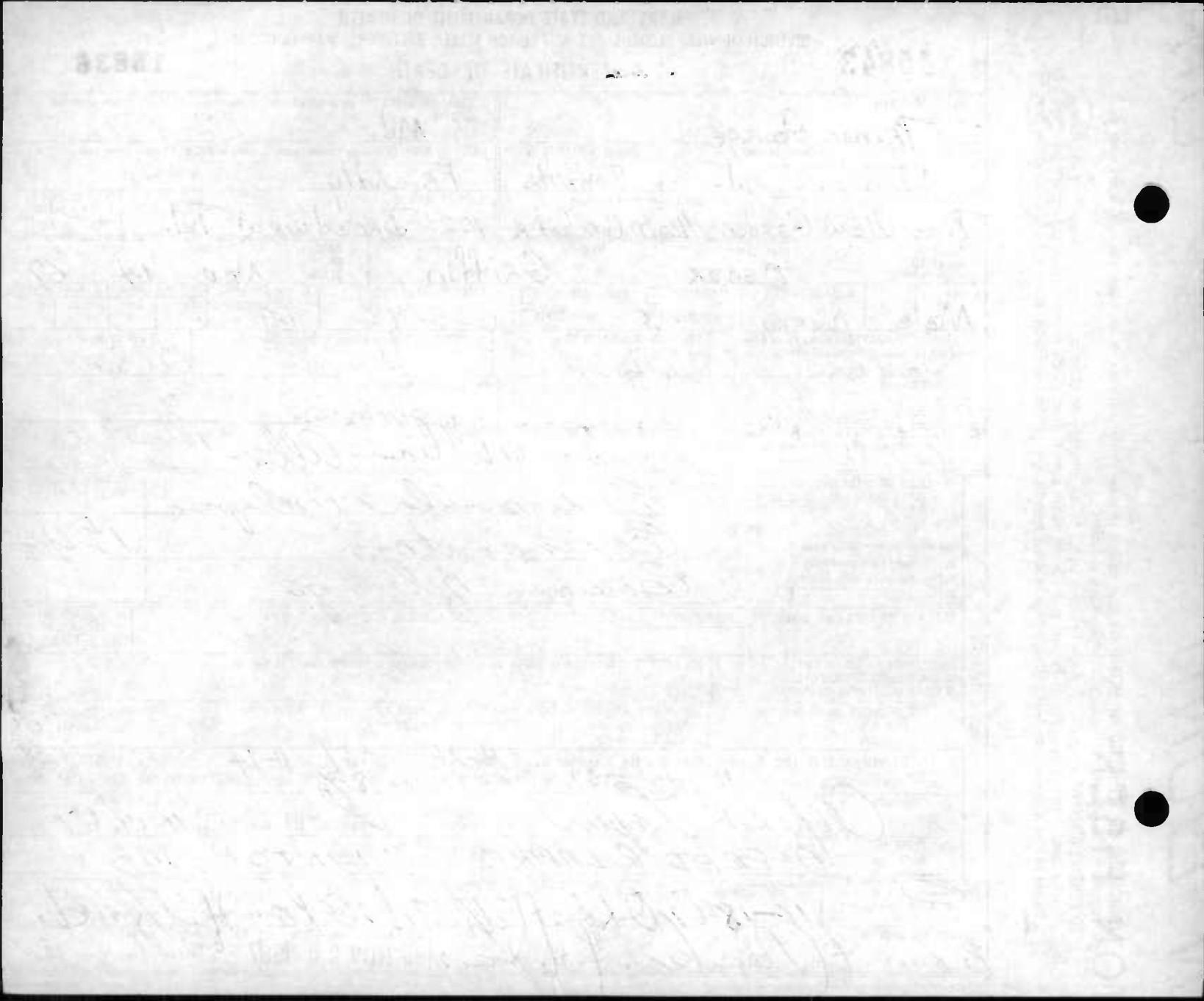
15836

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton, Md.</i>	c. LENGTH OF STAY IN 1b <i>7 months</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendly</i>	d. STREET ADDRESS <i>1021 Broadview Rd.</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pine View Gardens Health Care Center</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Oscar</i>	Middle <i></i>	4. DATE OF DEATH Month <i>Nov.</i> Day <i>14</i> Year <i>1967</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Lost <i>6-5-98</i>
9. NEVER MARRIED <input type="checkbox"/>	10. DIVORCED <input type="checkbox"/>	11. AGE (In years last birthday) <i>69 yrs.</i>	12. IF UNDER 1 YEAR Months <i></i>
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Handyman</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Georgia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Felix Griffin</i>	14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>579-10-2197</i>	17. INFORMANT <i>William Allen</i>	Address <i>1601 - 8th St NW Washington</i>
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>163X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) <i>Carcinomatous</i>			
DUE TO (c) <i>Carcinoma of lungs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour : o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i>Clinton, MD</i>		(County) <i></i>	(State) <i></i>
21. I certify that (I) (this hospital) attended the deceased from <i>11-26</i> , 19 <i>67</i> , to <i>11-14</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11-14</i> , 19 <i>67</i> , and that death occurred at <i>859</i> M, tram causes and on the date stated above.			
22a. SIGNATURE <i>Alfred R. Lapin</i>		22b. DATE SIGNED <i>11-14-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPIN, MD</i>		22d. ADDRESS <i>Clinton, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>16-18-67 Open Hill Md.</i>	23b. DATE THEREOF <i>16-18-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Open Hill Md.</i>	23d. LOCATION (City or town) (County) (State) <i>Open Hill Md.</i>
24. FUNERAL DIRECTOR <i>Brown &amp; Daileyson &amp; H. Inc.</i>	25a. REC'D BY REGISTRAR <i>NOV 20 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		d. STREET ADDRESS <b>R.R. Box 2250</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First	Middle	Lost	4. DATE OF DEATH <b>Nov. 9, 1967</b>	Month	Day	Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <b>WIDOWED</b>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/24/19</b>	9. AGE (In years last birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James G. Proctor</b>		14. MOTHER'S MAIDEN NAME <b>Cora Swann</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>William L. Griffith</b>		Address <b>Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5810</b>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		= Cirrhosis of Liver, severe		INTERVAL BETWEEN ONSET AND DEATH		
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(c)		Infarction and Hemorrhage of cerebrum and Cerebellum				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from _____, 19_____, to Nov. 9, 1967, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on Nov. 9, 1967, and that death occurred at 9:45 AM, from causes and on the date stated above.								
22c. PHYSICIAN'S NAME (Type) <b>A. Clark Holmes, M. D.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/10/67</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-13-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Resurrection Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Clinton, Prince George Co. Md.</b>		
24. FUNERAL DIRECTOR <b>Marcell Adams Aquasco, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

10881

NOTE THAT ADDRESS IS IN REVERSE ORDER AND IS 3000712

(NAME TO STAMP)

SEARCHED INDEXED

FOR STATE  
HEALTH DEPT.

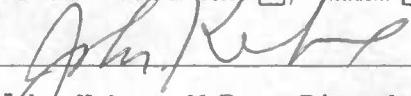
1  
TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

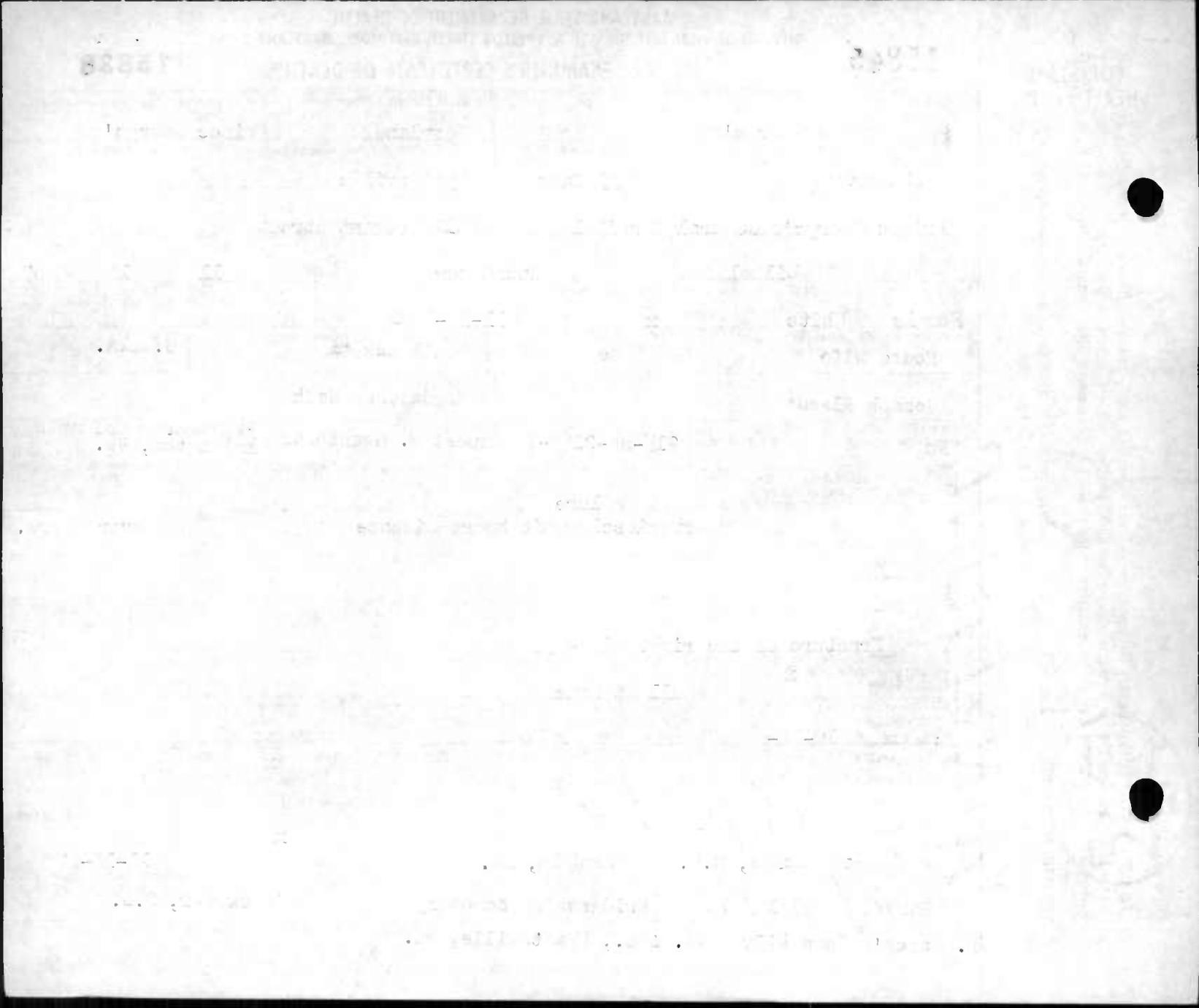
15845

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15838

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>33 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>8312 Fremont Street</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Wilhelmina</b>		First	Middle	Lost	4. DATE OF DEATH Month <b>11</b> Month <b>11</b> Doy <b>14</b> Year <b>1967</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-16-1882</b>	9. AGE (In years lost birthday) yrs. <b>84</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>	
13. FATHER'S NAME <b>Joseph Klaudt</b>			14. MOTHER'S MAIDEN NAME <b>Magdalena Welk</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. <b>215-48-2188-T</b>		17. INFORMANT <b>Rupert W. Guenthner</b> 3212 North Columbian Street, Arlington, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 4200 DUE TO <b>Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH over 2 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of the right hip - 33 days					
20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home</b>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>3:40 p.m. 10-12 1967</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Home		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>same as #2</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/18/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Bridgewater Cemetery</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>4739 Balt. Ave., Hyattsville, Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Bridgewater, S.D.</b>	
25a. REC'D BY REGISTRAR DATE <b>NOV 20 1967</b>		25b. REGISTRAR'S SIGNATURE 			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15846		15839			
<b>1. PLACE OF DEATH</b> a. COUNTY      Prince Georges      MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE      Maryland      b. COUNTY      Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 hrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> First      Baby      Middle      Lost (Type or print)      Girl      Hall		<b>4. DATE OF DEATH</b> Month      Doy      Year Nov.,      6      1967			
S. SEX      Female	6. COLOR OR RACE      Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Nov., 1967	9. AGE (In years lost birthday) yrs. 2	IF UNDER 1 YEAR Months      Days      Hours      Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Prince Georges Co. Nd	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Marie		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)      7615      DUE TO <i>Prematurity</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause      (b)      DUE TO <i>Atelectasis of lungs. bilateral.</i> (c)      DUE TO <i>Cephalhematoma.</i>				INTERVAL BETWEEN ONSET AND DEATH	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>MEDICAL CERTIFICATION</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m.      p.m.      19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town)      (County)      (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 6, 1967, to Nov. 6, 1967, that <input checked="" type="checkbox"/> (we) lost the deceased alive on Nov. 6, 1967, and that death occurred at 4:15 P.M. from causes and on the date stated above.					
22a. SIGNATURE <i>Bernardo Alvarado, M.D.</i>				22b. DATE SIGNED <i>Nov. 14, 1967</i>	
22c. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D.		22d. ADDRESS Prince Georges General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-11-67		23c. NAME OF CEMETERY OR CREMATORIUM Prince George's General		23d. LOCATION (City or Town)      (County)      (State) Cheverly, Md.	
24. FUNERAL DIRECTOR William A. Parker, Cheverly, Md.		ADDRESS	HOSPITAL	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

86362

THIS IS THE SAME FORM USED FOR APPROVAL OF THE COMMERCIAL BONDS.

RECEIVED  
MAY 20 1942

UNIVERSITY

REGISTRATION

CONFIRMATION

RECEIVED  
MAY 20 1942

50 UNIV. OF ILLINOIS

INDIVIDUALS REGISTERED ON THIS

DATE

1942

NAME

NAME

NAME

NAME

AND NUMBER REGD

NUMBER

RECEIVED MAY 20 1942

RECEIVED MAY 20 1942

RECEIVED MAY 20 1942

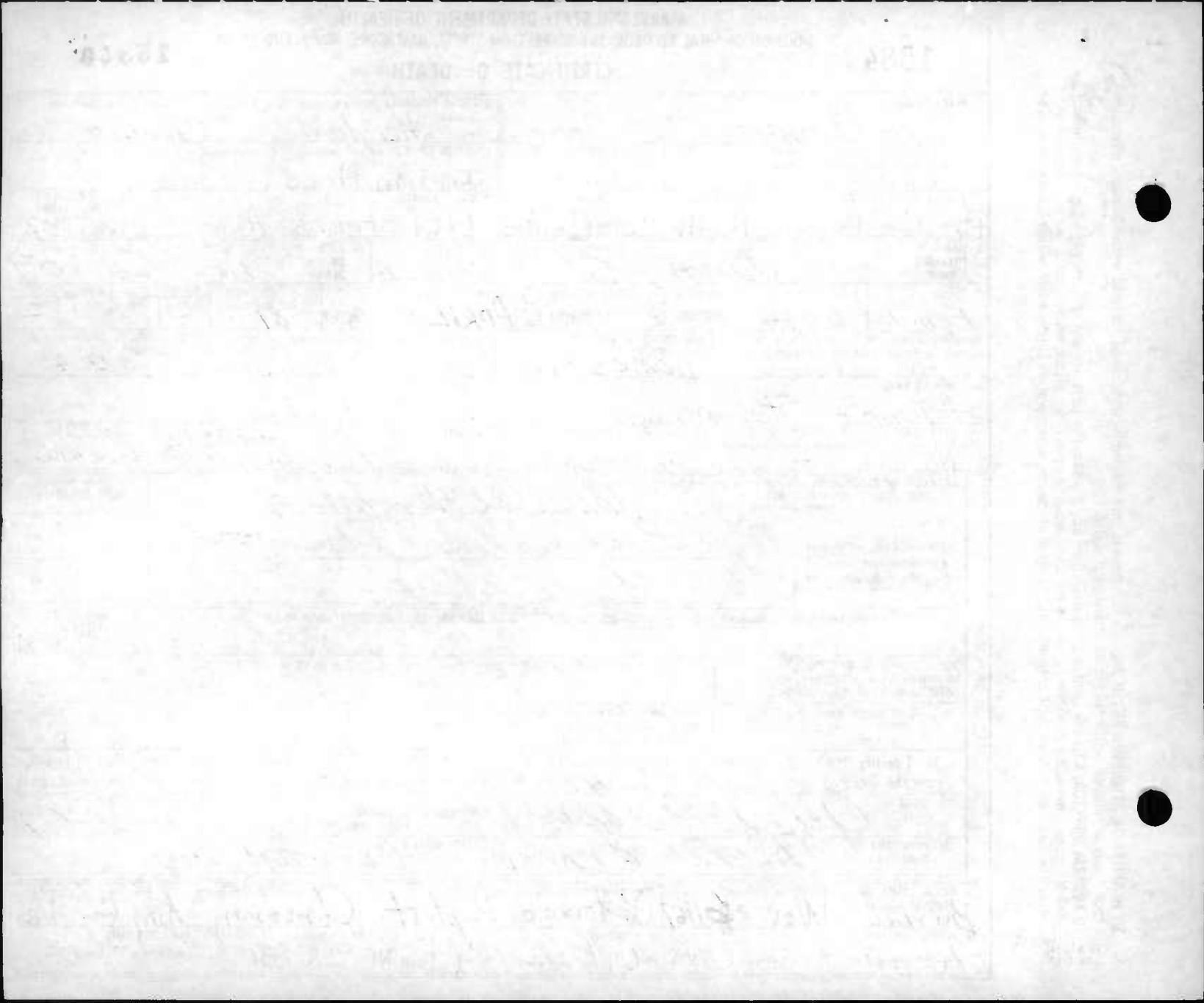
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <i>Pt. Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>	c. LENGTH OF STAY IN lb <i>2wks</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i>	d. STREET ADDRESS <i>1401 Strauss Ave.</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pine View Gardens Health Care Center</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>JULIA</i>	Middle <i>S.</i>	Last <i>HALLA</i>
4. DATE OF DEATH Month <i>11</i>	Month <i>23</i>	Day <i>1967</i>	Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>APRIL 12 1886</i>	9. AGE (In years last birthday) <i>81 yrs.</i>	10. IF UNDER 1 YEAR Months <i>-</i>	11. IF UNDER 24 HRS. Hours <i>-</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>DOMESTIC</i>	11. BIRTHPLACE (County & State, or foreign country) <i>(Accosian) Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>H. Temple Stevens</i>	14. MOTHER'S MAIDEN NAME <i>Betty Hughes</i>	Address <i>RFD Box 4311 AB Mrs Margaret Grimes Upper Marlboro, Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>212-16-4090-7</i>	17. INFORMANT <i>to Mrs Margaret Grimes</i>	INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4221</i>		<i>Cerebral Hemorrhage</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiovascular disease</i>		<i>Arteriosclerosis</i>	
(c) <i>Senile synder</i>		<i>Disease</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>Clinton, MD.</i>		(County) <i>Charles</i>	(State) <i>MD</i>
21. I certify that (I) (this hospital) attended the deceased from <i>11-10 1967</i> , to <i>11-23 1967</i> that (I) (we) last saw the deceased alive on <i>11-23 1967</i> , and that death occurred at <i>5302 M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Alfred R Lapan</i>		22b. DATE SIGNED <i>11-23-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>ALFRED R LAPAN, MD</i>		22d. ADDRESS <i>Clinton, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Nov. 26 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Thomas Baptist</i>	23d. LOCATION (City or Town) <i>Compton, King George, Va.</i>
24. FUNERAL DIRECTOR, <i>X Hornt Funeral Home, Waldorf Md</i>	ADDRESS <i>ADDRESS</i>	25a. REC'D BY REGISTRAR <i>Charles J. Judge</i>	25b. REGISTRAR'S SIGNATURE
		DATE <i>NOV 28 1967</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

15841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nanjemoy</b>		(Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence - 11653 Lamar Avenue</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Inez</b>	Middle <b>Virginia</b>	Lost	4. DATE OF DEATH	Month <b>November</b>	Day <b>12,</b>	Year <b>1967</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>December 5, 1886</b>	9. AGE (In years lost birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>King George, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry Carpenter</b>		14. MOTHER'S MAIDEN NAME <b>Nanny Burchill</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-54-0339</b>		17. INFORMANT <b>B Mrs. Vesta Holt-Daughter, S.E., Wash., D.C.</b>		Address <b>1411 - 19th. St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral (Arteriosclerosis) Hemorrhage, right side</b>						INTERVAL BETWEEN ONSET AND DEATH <b>One month</b>	
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b>						Two years	
DUE TO DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1331 Staples St., N.E., Washington, D.C.</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 28, 1967</b> , to <b>November 11, 1967</b> , that I last saw the deceased alive on <b>November 11, 1967</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>William J. P. Howard</i>		ADDRESS (Street, city or town, state) <b>1331 Staples St., N.E., Washington, D.C.</b>		DATE SIGNED <b>Nov. 12, 1967</b>			
PHYSICIAN'S NAME (Type) <b>William J. P. Howard, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/14/1967</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Nanjemoy Baptist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nanjemoy, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arehart Funeral Home, Inc.-La Plata, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>NOV 15 1967</b>		24b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
**page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.**

22305 5220 1971 F 2022

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15849

CERTIFICATE OF DEATH

15842

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		d. STREET ADDRESS <b>5610 Shadyside Avenue</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
74 3. NAME OF DECEASED (Type or print) <b>Nettie B. Hardy</b>		First	Middle	Lost	4. DATE OF DEATH <b>November 13 1967</b>	Month	Doy	Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/7/91</b>	9. AGE (In years lost birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Benjamin Hardy</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Cora Ferreola 3627 Silver Pk, Dr. Suitland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)		<i>Pulmonary Embolism</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Subacute bacterial pneumonia</i>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Autosomal Scleroderma / heart Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) <input type="checkbox"/> attended the deceased from <b>10-28-1967</b> to <b>11/13 1967</b> , that (I) <input type="checkbox"/> last saw the deceased alive on <b>11/13 1967</b> , and that death occurred at <b>3:16 M.</b> from causes and on the date stated above.										
22a. SIGNATURE <i>Francis D. Fowler</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	P.M.			22b. DATE SIGNED <b>22b. DATE SIGNED</b>
22b. PHYSICIAN'S NAME (Type) <b>Francis D. Fowler, M. D.</b>		22d. ADDRESS <b>4400 Stamp Rd. Marlow Hgts, Maryland</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/17/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Epiphany Church Cemetery</b>		23d. LOCATION (City or Town) <b>Forestville, Maryland</b>		(County) <b>PG</b>		
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b>		ADDRESS <b>4308 Suitland Road, Suitland, Maryland</b>		25a. RECD BY REGISTRAR <b>NOV 20 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>						
15850 44097 24/69ia			17501			
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Capitol Heights</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>6188 Rollins Avenue</b>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <i>Eugene Charles Baby Boy</i>		<b>4. DATE OF DEATH</b> <b>Harper</b> <b>Lost</b> <b>November 18, 1967</b>		<b>Month</b> <b>Doy</b> <b>Year</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Nov. 16, 1967</b>	<b>9. AGE (In years lost birthday yrs.)</b> <b>2</b>	<b>IF UNDER 1 YEAR</b> <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country)		
<b>13. FATHER'S NAME</b>			<b>14. MOTHER'S MAIDEN NAME</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Distress syndrome;</b> <b>7600</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Edema with congestion;</b> DUE TO (c) <b>Cerebral edema;</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> <input checked="" type="checkbox"/> <b>(s)</b> <b>(this hospital)</b> attended the deceased from <b>Nov. 16, 1967</b> , to <b>Nov. 18, 1967</b> , that <input checked="" type="checkbox"/> <b>(s)</b> <b>(we)</b> last saw the deceased alive on <b>Nov. 18, 1967</b> , and that death occurred at <b>12:45 PM</b> , from causes and on the date stated above.						
<b>22a. SIGNATURE</b> <i>Edwin Jensen</i>		<b>22b. DATE SIGNED</b> <i>Nov 24, 1967</i>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <i>Edwin Jensen, M.D.</i>		<b>22d. ADDRESS</b> <b>Prince Georges General Hospital</b>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> <input checked="" type="checkbox"/> <b>REMOVED</b>		<b>23b. DATE THEREOF</b> <i>12-9-67</i>		<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <b>Prince George's General Hosp. Cheverly, Maryland</b>		
<b>24. FUNERAL DIRECTOR</b> <i>Charles W. Penn, Jr. Administrator</i>		<b>ADDRESS</b>		<b>25a. REC'D. BY REGISTRAR</b> <b>DEC 18 1967</b>		
				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>		

1927

1928 to 1930

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1928

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1928 late

1928 recent night

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15843

1  
FOR STATE  
HEALTH DEPT

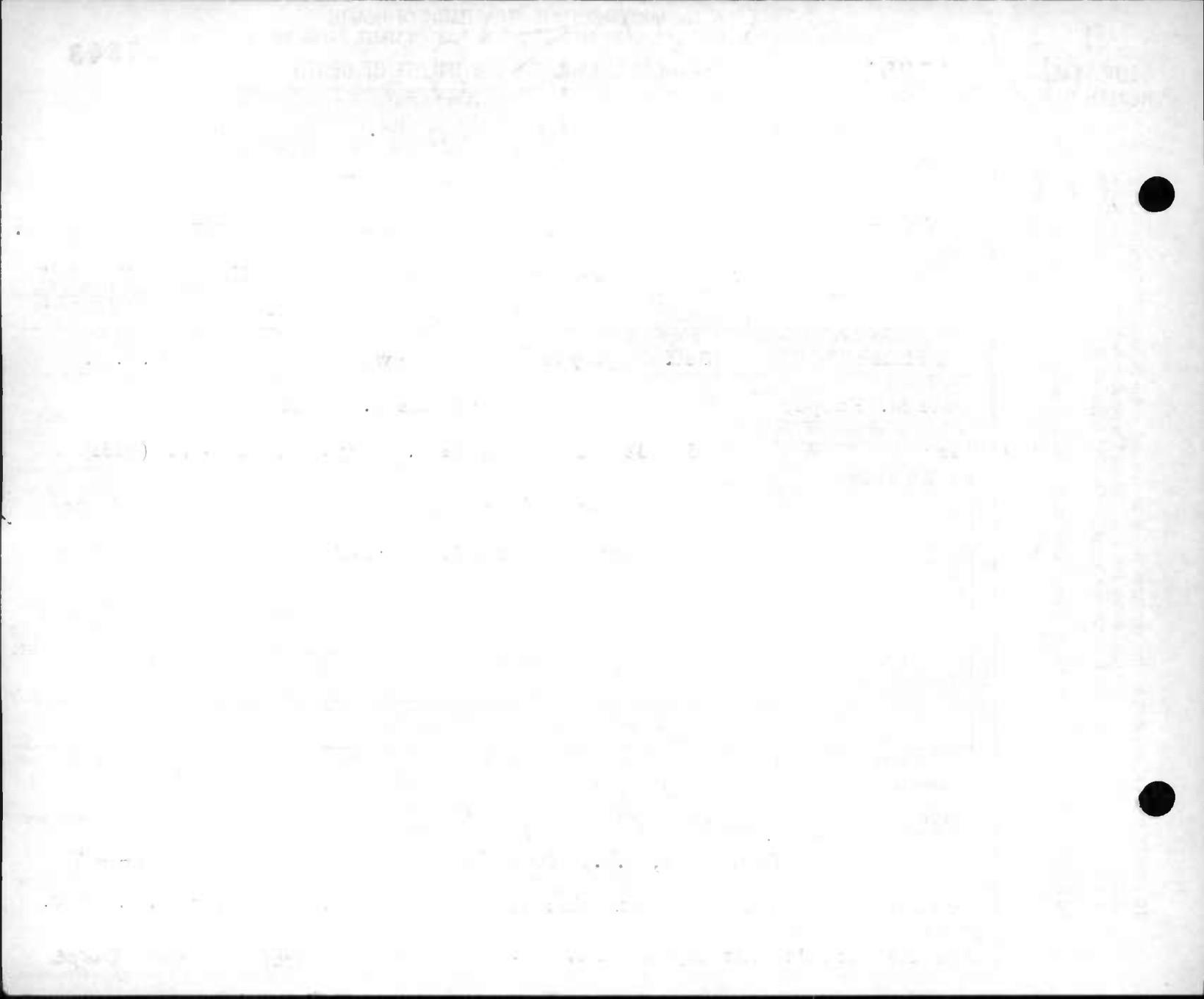
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMR Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15851

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		d. STREET ADDRESS 9322 Fontana Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank		First	Middle	Last	4. DATE OF DEATH 11	Month	Year 7 19 67
S. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 March 1926	9. AGE (In years lost birthday) 41 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Gale M. Harper				14. MOTHER'S MAIDEN NAME Carnie O. Evans			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Daphne R. Harper Same as #2 (wife)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Heart failure</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic heart disease</u> ONSET AND DEATH lost. (c) <u>unknown</u> MINUTES							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		Address (Street, city, town, or county) 11-7-67					
23a. BURIAL, CREMATION, BURIAL (Specify) Burial		23b. DATE THEREOF 11/7/67		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		23d. LOCATION (City or Town) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 9 1967		25b. REGISTRAR'S SIGNATURE jCharles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17502

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**\*\*Also known as Mary Alice Plunkett**

1. PLACE OF DEATH a. COUNTY      Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 2 mos., 3 wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ex Washington, D. C. 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 50 N St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice		First --	Middle Harris	Lost ** 4. DATE OF DEATH Month 11	Doy 29 Year 1967
S. SEX F	6. COLOR OR RACE N	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/10/1908	9. AGE (In years lost birthday) 59 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown - retired		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Parker		14. MOTHER'S MAIDEN NAME Elizabeth Green			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 579-14-8998		17. INFORMANT Decedent	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 443 X      Bronchopneumonia      INTERVAL BETWEEN ONSET AND DEATH 8 days DUE TO Recurrent cerebrovascular accidents with					
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.      (b) left hemiplegia      years DUE TO      Hypertensive and arteriosclerotic cardiovascular disease      years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Diabetes mellitus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.      19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)      (County)      (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/6/1967 to 11/29/1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/29/1967, and that death occurred at 11:30 AM, from causes and on the date stated above.					
22o. SIGNATURE <i>Moe Weiss</i>		M.D.      ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/29/67		
22c. PHYSICIAN'S NAME (Type)      Moe Weiss, M. D.		22d. ADDRESS      Glenn Dale Hospital Glenn Dale, Md.			
23o. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-1-67	23c. NAME OF CEMETERY OR CREMATORIAL Harmony mem. park	23d. LOCATION (City or Town) (County) (State) Landover Crematory	
24. FUNERAL DIRECTOR UNIVERSAL Funeral Home ADDRESS 816-61-814 E Washington D.C.		25o. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 25M 1/67		DATE DEC 11 1967			

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FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16

2

2

VR A15ME (5)  
6M 1/67

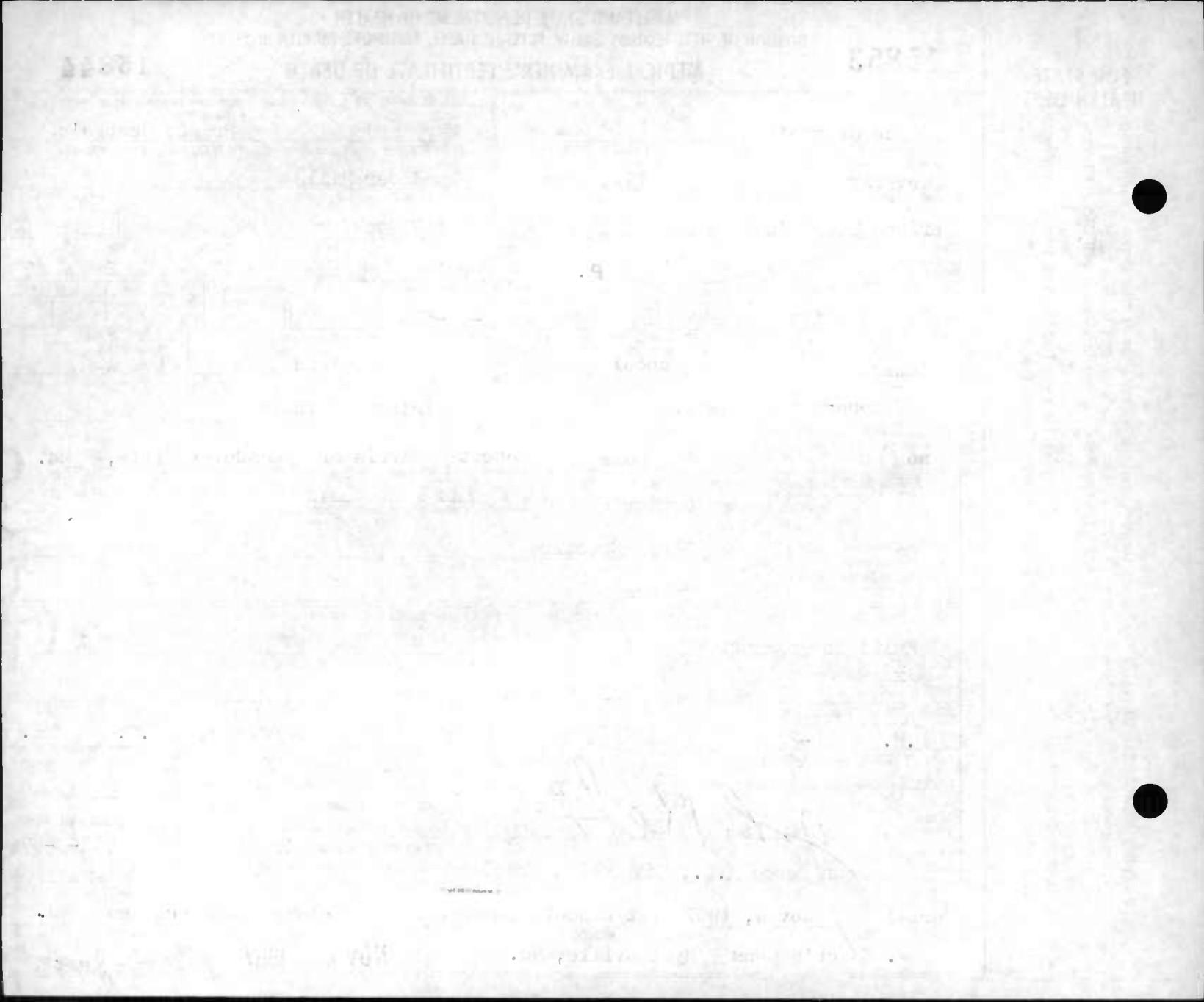
15853

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15844

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>five days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b>		d. STREET ADDRESS <b>4817 Rockford Drive</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Robert</b>		First <b>P.</b>	Middle <b>P.</b>	Lost <b>Harris</b>	4. DATE OF DEATH <b>11</b>	Month <b>2</b>	Doy <b>19</b>	Year <b>67</b>	
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-30-59</b>	9. AGE (In years lost birthday) <b>8</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Robert P Harris sr</b>				14. MOTHER'S MAIDEN NAME <b>Shirley A Baldwin</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Robert P Harris Sr</b>		Address <b>Landover Hills, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Contusion and Laceration of brain				INTERVAL BETWEEN ONSET AND DEATH			
9040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Skull Fracture							
(c)		Trauma							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Multiple Pulmonary Emboli									
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>fell at home</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>P.M. 10-28 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) <b>Landover, P.G.</b>		(County) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		Address (Street, city, town, or county)		22. DATE SIGNED <b>11-3-67</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 4, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) <b>Colmar Manor Pro Geo</b>		(County) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE			
				DATE <b>NOV 6 1967</b>					



~~FOR STATE  
HEALTH DEPT~~

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form LNM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15854

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 film G395 12/12/67 kk

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

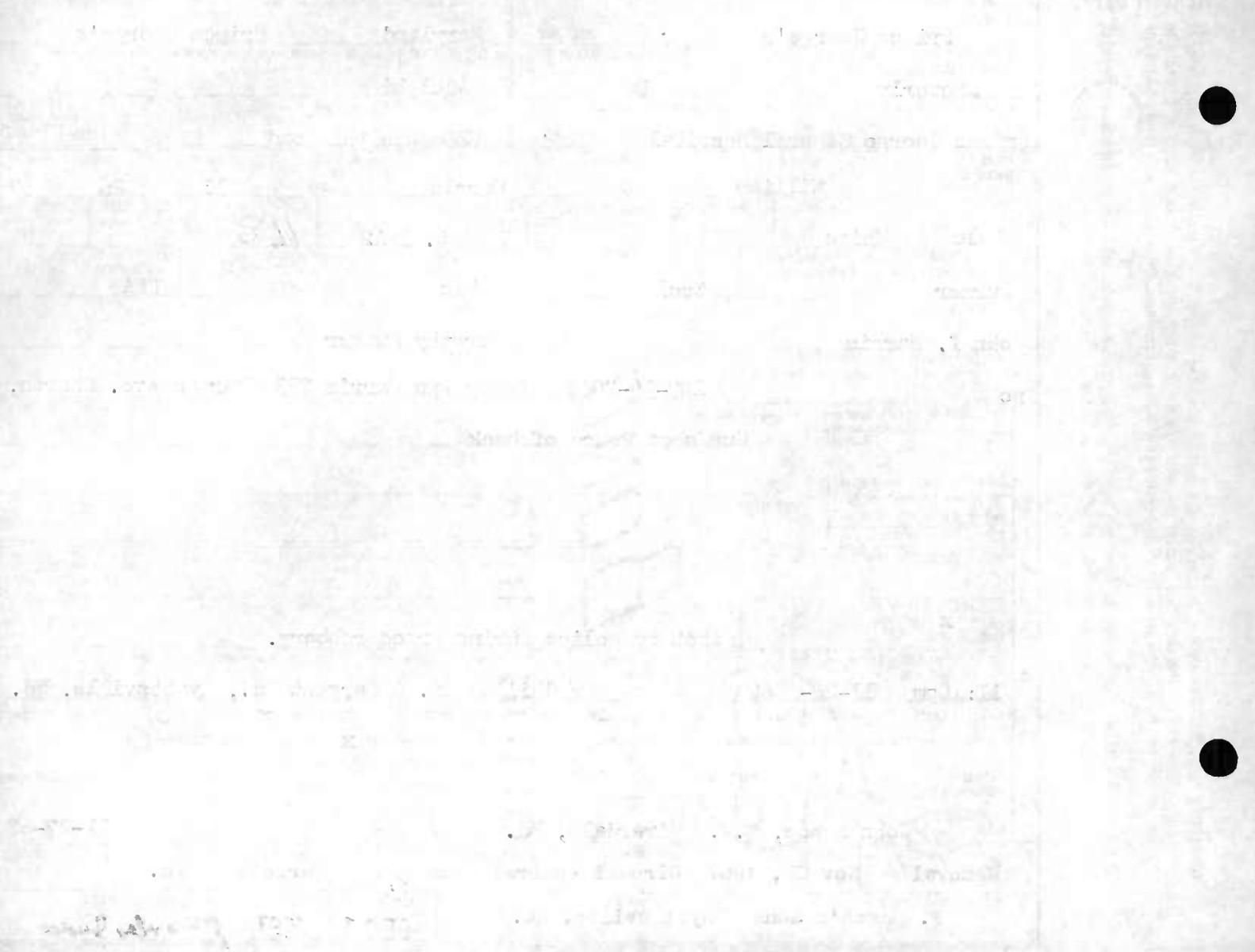
15845

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>			d. STREET ADDRESS <b>9284 Adelphi Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William C Harris</b>		First	Middle	Last	4. DATE OF DEATH 11 26 19 67	Month Doy Year	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 Sept. 1942</b>		9. AGE (In years last birthday) <b>61 25 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Burner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John f. Harris</b>			14. MOTHER'S MAIDEN NAME <b>Dorothy Swager</b>			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>287-36-2088</b>		17. INFORMANT <b>Betty Ann Harris 733 Sherman Ave. Sharon, Pa.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of back</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>Shot by police during armed robbery.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11:10pm. 11-26-19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>Chillum Rd. &amp; Sargent Rd., Hyattsville, Md.</b>	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED <b>11-27-67</b>
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>John Kehoe, M.D. Riverdale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>Nov 28, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Giroski Funeral Home</b>	23d. LOCATION (City or Town) (County) (State) <b>Farrell Pa.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>			ADDRESS	25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>	25b. REGISTRAR'S SIGNATURE 		

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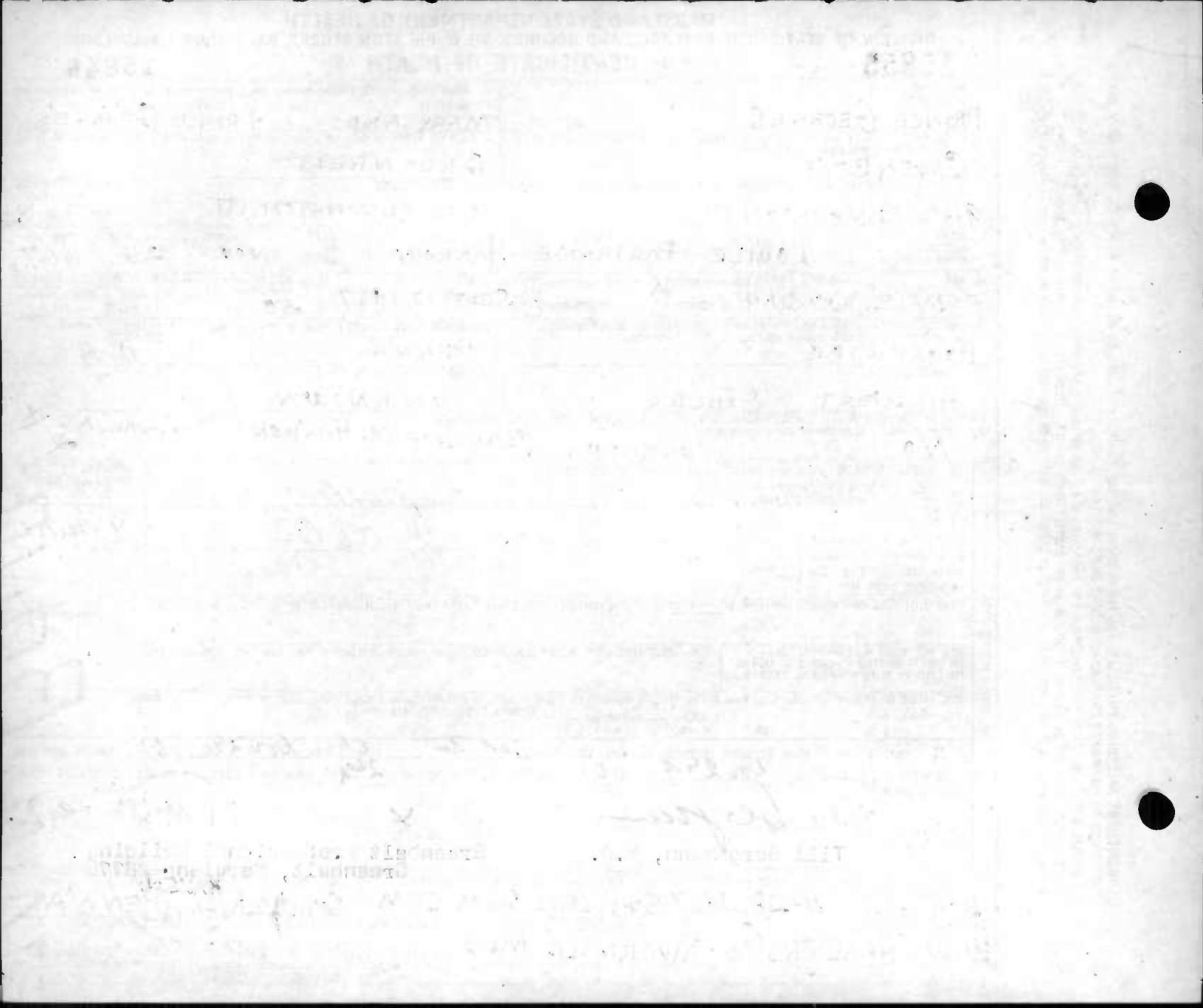
10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
15855				15846													
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MARYLAND</b>													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GREENBELT</b>				b. COUNTY <b>PRINCE GEORGE'S</b>													
c. LENGTH OF STAY IN 1B				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GREENBELT</b>													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9102 EDMONSTON CT.</b>				d. STREET ADDRESS <b>9102 EDMONSTON CT</b>													
3. NAME OF DECEASED (Type or print) <b>LOUISE PARTRIDGE HARRON</b>				First	Middle	Last	4. DATE OF DEATH <b>NOV 24 1967</b>	Month	Day	Year							
5. SEX <b>FEMALE</b>				6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 17, 1917</b>	9. AGE (in years last birthday) <b>50 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Hours	Days	Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PENNA</b>				11. BIRTHPLACE (County & State, or foreign country) <b>PENNA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>					
13. FATHER'S NAME <b>HILBERT SIBLER</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>UNKNOWN</b>				17. INFORMANT <b>CLARENCE M. HARRON</b>				Address <b>SAME AS</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 1538 IMMEDIATE CAUSE (a)				generalized carcinoma carcinoma of colon								INTERVAL BETWEEN ONSET AND DEATH 6 mos					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO												9. month					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 31, 1961</b> , to <b>Nov 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 28, 1967</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.												22b. DATE SIGNED <b>11-29 1967</b>					
22a. SIGNATURE <i>Vin Bergmann</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22b. DATE SIGNED <b>11-29 1967</b>					
22c. PHYSICIAN'S NAME (Type) <b>Till Bergemann, M.D.</b>				22d. ADDRESS <b>Greenbelt Professional Building Greenbelt Maryland 20770</b>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>11-28-1967</b>				23c. NAME OF CEMETERY OR CREMATORIUM <b>SCHUYLKILL MEM CEM</b>				23d. LOCATION (City, Town or County) (State) <b>SCHUYLKILL, PENNA.</b>					
24. FUNERAL DIRECTOR <b>W.W.CHAMBERS Co</b>				ADDRESS <b>RIVERDALE, MD.</b>								25a. REC'D BY REGISTRAR DATE <b>NOV 27 1967</b>				25b. REGISTRAR'S SIGNATURE <i>W. Chambers Judge</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm Page 5 may be retained for your files.

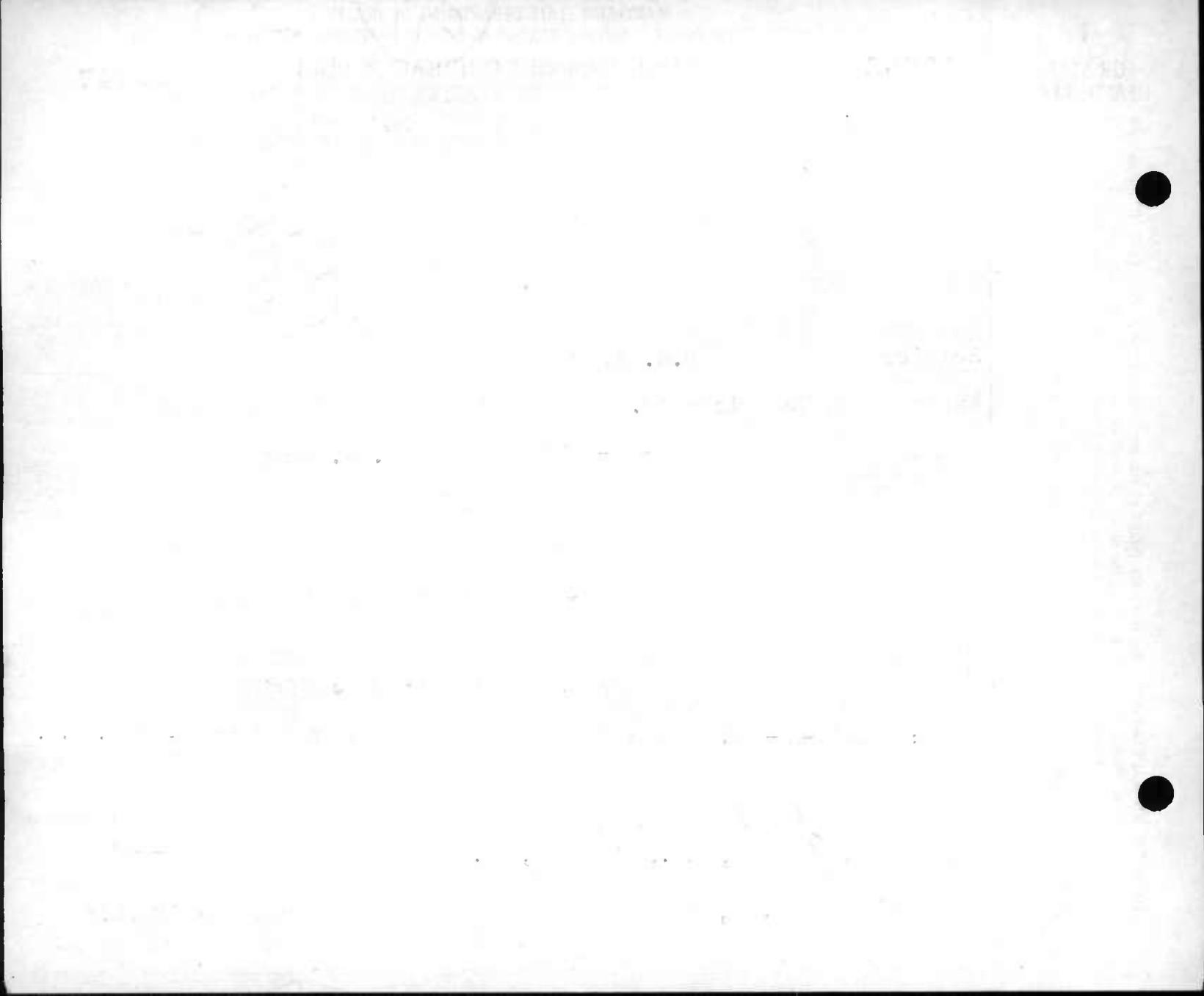
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15856

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15847

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE California b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upland 43-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 1204 Winston Court		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Warren	Middle Glen	Lost Hendricks	4. DATE OF DEATH 11	Month 5
5. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24 1947	9. AGE (In years lost birthday) 20 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Warren Glen Hendricks Sr.			14. MOTHER'S MAIDEN NAME Lorraine June ( Unknown)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 566-74-3525		17. INFORMANT Records U. S. Army	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8164 Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Skull Fracture DUE TO (c) Trauma - auto accident					
INTERVAL BETWEEN ONSET AND DEATH 22 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in collision Maryland			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 11:50 p.m 10-14-1967		20d. INJURY OCCURRED 3 While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore Washington Parkway Laurel, P.G.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED 11-6-67	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Ontario, California	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. , 1967		23c. NAME OF CEMETERY OR CREMATORIAL Belvieu	
24. FUNERAL DIRECTOR HOWARD COUNTY FUNERAL HOME of Harry Witzke		ADDRESS Ellicott City Maryland		23d. LOCATION (City or Town) (County) (State) Ontario, California	
25a. REGD. BY REGISTRAR NOV 8 1967		25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>		DATE	



FOR STATE  
HEALTH DEPT

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15857  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15848

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>5015 Hays St., N.E.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Mannie</b>		First	Middle	Lost	4. DATE OF DEATH <b>Hill</b>	Month <b>11</b>	Doy <b>20</b>	Year <b>1967</b>
S. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 May 1912</b>	9. AGE (In years lost birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS. DAYS <b>1</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John T. Jordan</b>		14. MOTHER'S MAIDEN NAME <b>Nannie?</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Bessie Stewart - neice</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>0120</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				Peritonitis fr.		INTERVAL BETWEEN ONSET AND DEATH		
				Bilateral ileo psoas abscesses		Unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>11-21-67</b>		
EXAMINER'S NAME (Type) <b>John Kehoe, M.D., Riverdale, Md.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) <b>Highland Park Rd</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-25-67</b>		23c. NAME OF CEMETERY OR CREMATORIALY <b>Harmony</b>		23d. LOCATION (City or Town) <b>Highland Park Rd</b>				
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Sons 4925 Penn Ave</b>		ADDRESS <b>4925 Penn Ave</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>		

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WILSON'S SPARROW

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15853

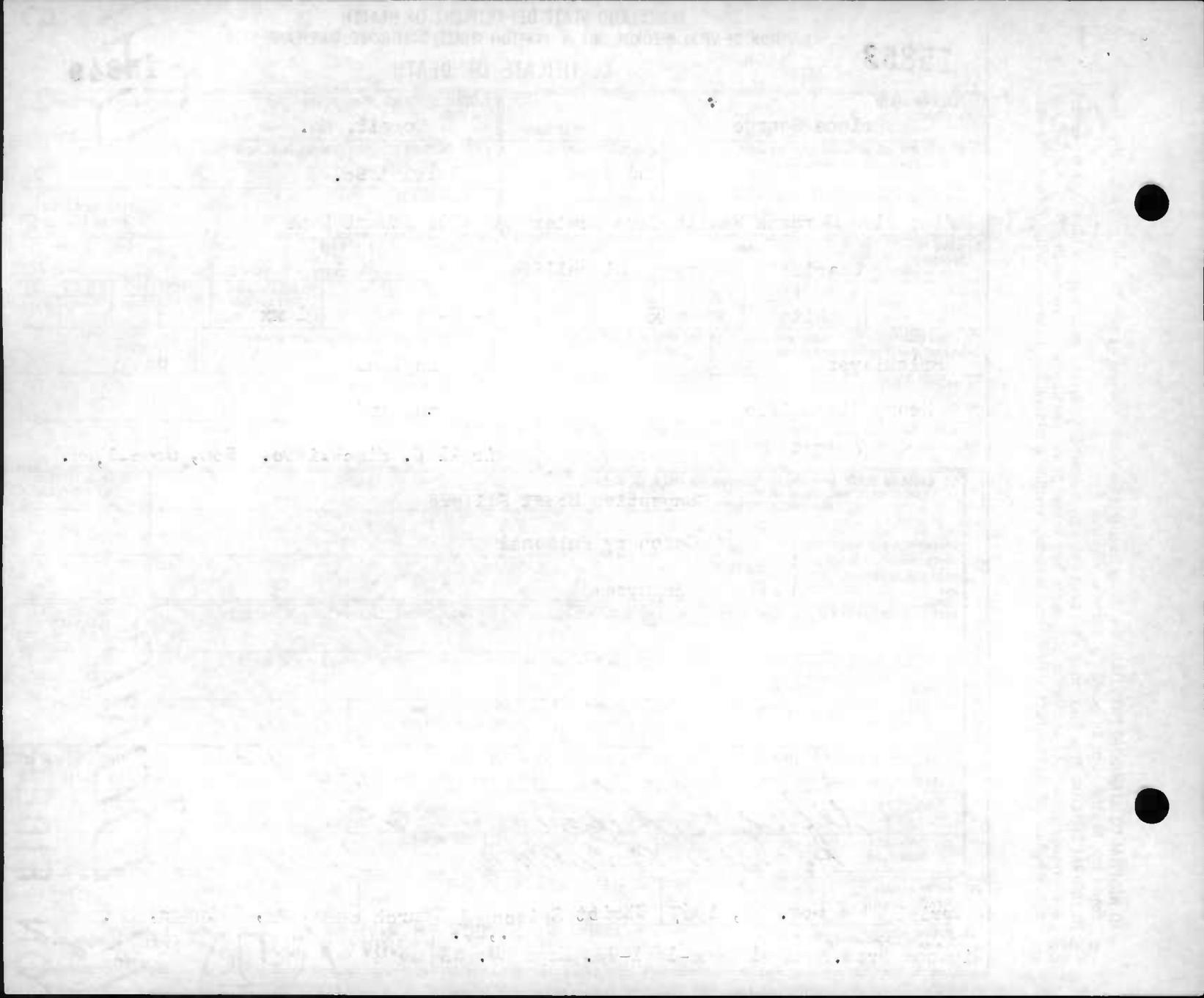
CERTIFICATE OF DEATH

15849

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Dowell, Md. b. COUNTY CALVERT					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 56 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calvert Co. DOWELL 06-2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine View Gardens Health Care Center			d. STREET ADDRESS 4701 Stuart Lane					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Charles Henry Hinchliffe			Middle	Lost	4. DATE OF DEATH Month November 27 1967			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-86	9. AGE (In years lost birthday) 81 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) England				
13. FATHER'S NAME Henry Hinchliffe			14. MOTHER'S MAIDEN NAME Ann Ward					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5271			Congestive Heart Failure					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
(b) Coronary Pulmanal								
DUE TO Emphysema								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-2, 1967, to 11-27, 1967, that (I) (we) last saw the deceased alive on 11-27, 1967, and that death occurred at 11:30 AM, from causes and on the date stated above.								
22a. SIGNATURE Alfred R. Lapin			ATTENDING M.D. PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN								
22d. ADDRESS Clinton, MD								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Nov. 29, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Christ Episcopal Church Cemetery		23d. LOCATION (City or Town) (County) (State) Clinton, Md.	
24. FUNERAL DIRECTOR Simmons Bros.			ADDRESS Wash. DC.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge	
Simmons Bros. Funeral Home-1661-Gd. Hope RD. SE								

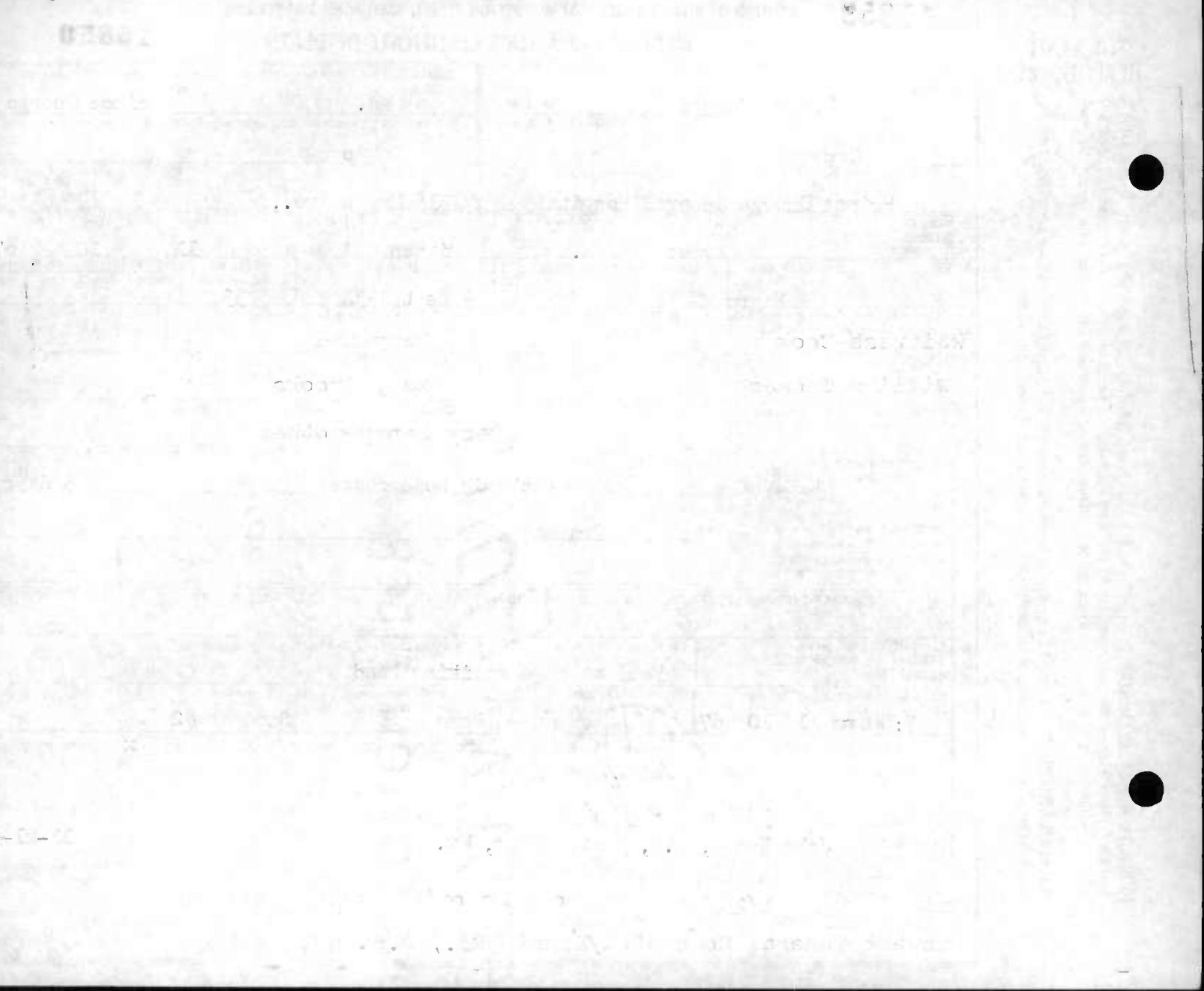


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY  Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY Prince George											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly DOA			c. LENGTH OF STAY IN 1b Bowie			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16-1											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital						d. STREET ADDRESS 316 Maple Ave.,											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)		First Agnes	Middle M.	Last Hinton	4. DATE OF DEATH 11 20 19 67	Month	Day	Year									
S. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Sept 1934	9. AGE (In years last birthday) 33 yrs.	IF UNDER 1 YEAR Months	Days	Hours	Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress-Cook				11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME William Thomas		14. MOTHER'S MAIDEN NAME Mary Brooks															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Henry-mother		Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Trauma (c)		Subarachnoid hemorrhage										INTERVAL BETWEEN ONSET AND DEATH 5 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home striking head															
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7:00 p.m. 11 10 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Same as #2		(County)		(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22. DATE SIGNED 11-21-67					
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) John Kehoe, M.D., Riverdale, Md.															
EXAMINER'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE THEREOF 11/25/67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Harmony Memorial Park		23d. LOCATION (City or Town) Maryland	
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd., N.E.		25a. REC'D BY REGISTRAR NOV 22 1967										25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15ME (5) 6M 1/67																	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15851

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN lb <b>19 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elmer L. Hollowell</b>		First	Middle
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truckdriver</b>		10b. KIND OF BUSINESS OR INDUSTRY --	
13. FATHER'S NAME <b>Clate Hollowell</b>		14. MOTHER'S MAIDEN NAME <b>Laura Ridley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes 1947-1949</b>		16. SOCIAL SECURITY NO. <b>377-24-4893</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of the liver, decompensated</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b> 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ stating the underlying cause lost. DUE TO (c) <b>chronic alcoholism</b> 20 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>alcoholic cardiomyopathy with congestive failure</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10/30/67</b> , 19 67 to <b>11/18/19 67</b> , thot <input checked="" type="checkbox"/> (we) last saw the deceased alive an <b>11/18/19 67</b> , and thot death occurred at <b>12:00A</b> M, from causes ond ond the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11/18/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 24, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Harmony Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Landover Pr. Geo. Md</b>	
24. FUNERAL DIRECTOR <b>B.F. Taylor</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>	

## **animal society**

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**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15852

1. PLACE OF DEATH o. COUNTY <b>PRINCE GEORGE MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Manor-4922 La Salle Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Anna</b>	Middle <b>Christina</b>	Last <b>Horan</b>
4. DATE OF DEATH <b>11 13 67</b>	Month	Day	Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>12-15-1882</b>	9. AGE (In years last birthday) <b>84 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13. FATHER'S NAME <b>Benjamin Hellyard</b>	14. MOTHER'S MAIDEN NAME <b>Maye Sauter</b>	Address <b>4922 La Salle Rd.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Sister Eliabeth</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central Arterial right side</b> 331X DUE TO <b>Hypotension</b> INTERVAL BETWEEN ONSET AND DEATH <b>9/9/1967 (4 days)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Arteries colles generally</b> <b>9/7/1940</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/7/1967</b> to <b>9/10/1967</b> , that (I) (we) last saw the deceased alive on <b>9/10/1967</b> , and that death occurred at <b>74M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>R. Wagner McDonald</b>	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>9/14/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Hospitaler McDonald</b>	22d. ADDRESS <b>1746 K St NW Wash DC</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-14-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Arlington Natl Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>	ADDRESS	25a. REC'D BY REGISTRAR DATE <b>NOV 17 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #23c Film#G391 11/14/67 ph

CERTIFICATE OF DEATH

15862				15853	
1. PLACE OF DEATH Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) District of Columbia n/a		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 1829 Q Street, SE		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Harriet	Middle E.	Lost Howard	4. DATE OF DEATH Nov. 6, 1967
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan 20 1884	9. AGE (In years lost birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Mass.	
13. FATHER'S NAME Henry Stratton			14. MOTHER'S MAIDEN NAME Ellen Hartley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Earnest C. Howard ( Husband ) Same as # 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pedney Edson</i> 4200 DUE TO <i>arteriosclerosis &amp; heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>atherosclerosis</i> (c) DUE TO <i>hypertension</i>					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>decrepit skeleton &amp; debility</i>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <i>act</i> , 19 <i>67</i> , to <i>death</i> , 19 <i>67</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>11/6</i> 19 <i>67</i> , and that death occurred at <i>10</i> M, from causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. SIGNATURE <i>Leon R. Levitsky</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M. D.		22d. ADDRESS 3408 Rhode Island Ave. Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF NOV. 8th, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Washington National Cemetery - Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros. 1661- Gd. Hope Rd. SE. Wash., DC		ADDRESS		25d. REC'D BY REGISTRAR	
				25b. REGISTRAR'S SIGNATURE Charles J. Judge	
				DATE NOV 8 1967	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15863

15854

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Chancery of Prince George's Co.*

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> -DOA-		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>3900 Hamilton St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ELsie</b>	Middle <b>M.</b>	4. DATE OF DEATH <b>Nov. 25, 1967</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 22, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Mann</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Wilmer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. <b>220-54-0361-J1</b>	
17. INFORMANT <b>Anne M Hoyle</b>		Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary thromboses</b> INTERVAL BETWEEN ONSET AND DEATH 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) <b>coronary arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) <b>Attended the deceased from Nov. 25, 1967, to Nov. 25, 1967,</b> that (I) <b>saw the deceased alive on Nov. 25, 1967,</b> and that death occurred at <b>XX-XXXX</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Don B. Cameron</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11-25-67</b>
22c. PHYSICIAN'S NAME (Type) <b>Don B. CAMERON</b>		22d. ADDRESS <b>3503 PINE ST. Hyattsville MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 28, 1967</b>	23c. NAME OF CEMETERY OR CEMETORY <b>Chester Cemetery</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>FC 1 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

42821

1970-30-31-AW1913

61937

1970-30-31-AW1913

Items 18&21 Film 396 1-9-67 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15864

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15855

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland</b>		c. LENGTH OF STAY IN 1b <b>44 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Regent Nursing Home</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights</b>		d. STREET ADDRESS <b>2329 Fairlawn Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Martha</b>		First	Middle	Lost	4. DATE OF DEATH <b>Huffman</b>	Month <b>11</b>	Doy <b>3</b>	Year <b>19 67</b>	
S. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-24-97</b>	9. AGE (In years lost birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS. DAYS <b>16</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>GERMANY</b>			
13. FATHER'S NAME <b>GUSTAV JEBE</b>				14. MOTHER'S MAIDEN NAME <b>LAURA TESCHEMACHER</b>		Address <b>7209 16th Ave Takoma Park Md</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS LORA MIKA</b>		INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Undetermined</b> 7955 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF <b>11/7/67</b>		23c. NAME OF CEMETERY OR CREMATORIALy <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) <b>Pr Geo Co Md.</b>			
24. FUNERAL DIRECTOR <i>John W. Kehoe &amp; Son</i>		ADDRESS <b>5232 Laurel</b>		25a. REC'D BY REGISTRAR <b>Nov 9 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

315 L. SPECIES

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15856

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASH. D.C.</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASH. D.C.</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL MANOR 4922 LASALLE RD.</b>			d. STREET ADDRESS <b>821 Emerson St. N.W.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>JOSEPHINE</b>	Middle <b>HUNNICKT</b>	Last <b>HUNNICKT</b>	4. DATE OF DEATH <b>Nov. 13 1967</b>	Month <b>Nov.</b>	Day <b>13</b>	Year <b>1967</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/> <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 3, 1879</b>	9. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Retired sales lady-Saks Fur Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WASH. D.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOSEPH HESSE</b>				14. MOTHER'S MAIDEN NAME <b>JOSEPHINE HAS</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-01-4637</b>		17. INFORMANT <b>St. Bernadette Joseph 4922 La Salle Ln</b>			Address <b>Hyattsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1992</b>		DUE TO <b>TANITION AND MALNUTRITION</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <b>Abdominal Malignancy undet. Type</b>					3 months			
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>July</b>		(County) <b>NOV</b>		(State) <b>1967</b>
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 1967, to <b>NOV</b> , 1967, that (I) ( <input checked="" type="checkbox"/> ) last saw the deceased alive on <b>NOV 10 1967</b> , and that death occurred at <b>2:10 PM</b> , from causes and on the date stated above.										22b. DATE SIGNED <b>11/13/67</b>
22a. SIGNATURE <b>James J. Foster</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <b>James J. Foster</b>		22d. ADDRESS <b>1746 Kst. N.W.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>11/16/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>			23d. LOCATION (City or Town) <b>Suitland</b>		(County) <b>Md.</b>	(State)
24. FUNERAL DIRECTOR <b>S.H. Hines Co. Wash. D.C.</b>		ADDRESS		25a. RECD BY REGISTRAR <b>Charles Judge</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 17 1967</b>	

2025 RELEASE UNDER E.O. 14176

1100-100-3140

1100-100-3140

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15866

15857

CERTIFICATE OF DEATH

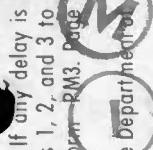
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Pro Geo</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>28 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>167 Prince George's General Hospital</b>	
d. STREET ADDRESS <b>3704 Jefferson st</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bertha C Issing</b>		4. DATE OF DEATH Month Day Year <b>Nov 24, 1967</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 11, 1896</b>	
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn N Y</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Burkhardt</b>		14. MOTHER'S MAIDEN NAME <b>Rose Weik</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>092 07 5976A</b>	
17. INFORMANT <b>Hospital records Cheverly, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>170X</b> (b) <b>Carcinoma of Breast</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-13</b> , 1967, to <b>11-23</b> , 1967, that (I) (we) last saw the deceased alive on <b>11-23</b> , 1967, and that death occurred <b>5-20A M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>11-23-67</b>	
22o. SIGNATURE <b>Aaron Deitz</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M. D.</b>		22d. ADDRESS <b>Prince Georges Plaza, Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 27, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
		25a. REC'D BY REGISTRAR DATE <b>NOV 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DERT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Prince George's Maryland</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>			c. LENGTH OF STAY IN lb <b>6 hours</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg, Md.</b>			d. STREET ADDRESS <b>4275 58th avenue</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First <b>Frances Jane Johnson</b>			Middle Last			4. DATE OF DEATH <b>Nov 12, 1967</b>		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 25, 1918</b>		9. AGE (In years last birthday) <b>48 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>				11. BIRTHPLACE (State or foreign country) <b>Pro Geo co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William B Markward</b>						14. MOTHER'S MAIDEN NAME <b>Ruth V Dempsey</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Edward F. Johnson Bladensburg, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hematoma</b> 7955 DUE TO Trauma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c) lost.											
INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Unknown</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)											
ACTUAL SIGNATURE <i>John Kehoe</i>				M.O.				22. DATE SIGNED <b>11-13-67</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Wood Cemetery</b>		23d. LOCATION (City or Town) <b>Vienna</b>		(County) <b>Va.</b>		(State)	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>						ADDRESS		25a. REC'D BY REGISTRAR DATE <b>DEC 1 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15ME (5) 6M 1/67											

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FOR STATE  
HEALTH DEPT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

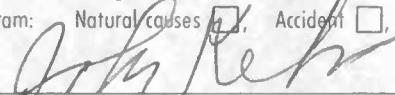
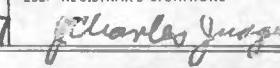
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15863

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15859

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>nine hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>		d. STREET ADDRESS <b>Box 229-C Floral Park Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Marie</b>	Middle <b>Elizabeth</b>	Last <b>Johnson</b>	4. DATE OF DEATH <b>11 4 1967</b>	Month	Day	Year	
S. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-1914</b>	9. AGE (In years last birthday) <b>23 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Pr. Geo's. Co. Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Richard Duckett</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Hawkins</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT <b>Preston Johnson</b>	Address <b>Same</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> DUE TO <b>981X</b>								INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO _____ last _____ (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>shot by assailant</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1:50pm p.m. 11-4 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>driveway of Box 369, Brandywine, P.G., Md.</b>		20f. (City or town) <b>Brandywine, P.G., Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>								22. DATE SIGNED <b>11-6-67</b>	
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.							
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-11-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Ch. Cem.</b>		23d. LOCATION (City or Town) <b>Brandywine P.G. Md.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Martell Adams Aquasco, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>		25b. REGISTRAR'S SIGNATURE 			

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

**15869** **15860**

1. PLACE OF DEATH a. COUNTY <b>P.G.</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>1002 Palmer Rd. SE P.G.</b> b. COUNTY <b>md/61</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b>		c. LENGTH OF STAY IN lb <b>7-14-67</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Regent Nursing Home</b>			d. STREET ADDRESS <b>1002 - palmer Road &amp; S.</b>		
3. NAME OF DECEASED (Type or print)		First <b>Claude</b>	Middle <b>H.</b>	Last <b>Jones</b>	4. DATE OF DEATH Month <b>11</b> Day <b>12</b> Year <b>1967</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>3-17-08</b>	9. AGE (In years last birthday) <b>59 yrs.</b> IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bank Driver Retired as govt.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>James Jones</b>		14. MOTHER'S MAIDEN NAME <b>Emma Nichols</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lucille D. Smith. (Dau.) #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>metastatic Prostatic Carcinoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 mos</b>			
(b) DUE TO (c)		<b>5 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>Washington</b> (County) <b>D.C.</b> (State) <b>D.C.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>7-14</b> , 1967, to <b>11-12</b> , 1967, that (I) (we) lost saw the deceased alive on <b>11-11</b> 1967, and that death occurred at <b>11:00 A.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>WB Sheer</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11-12-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>WALTER B. SHEER</b>		22d. ADDRESS <b>6400 MARLBORO Pike S.E. Wash. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 14-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		ADDRESS <b>Simmons Bros. 1661- Gd. Hope RD. SE. Wash., DC</b>		25a. REC'D. BY REGISTRAR <b>NOV 13 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

9382

RECEIVED  
LIBRARY OF CONGRESS  
JULY 1967

9382

REF ID: A671

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

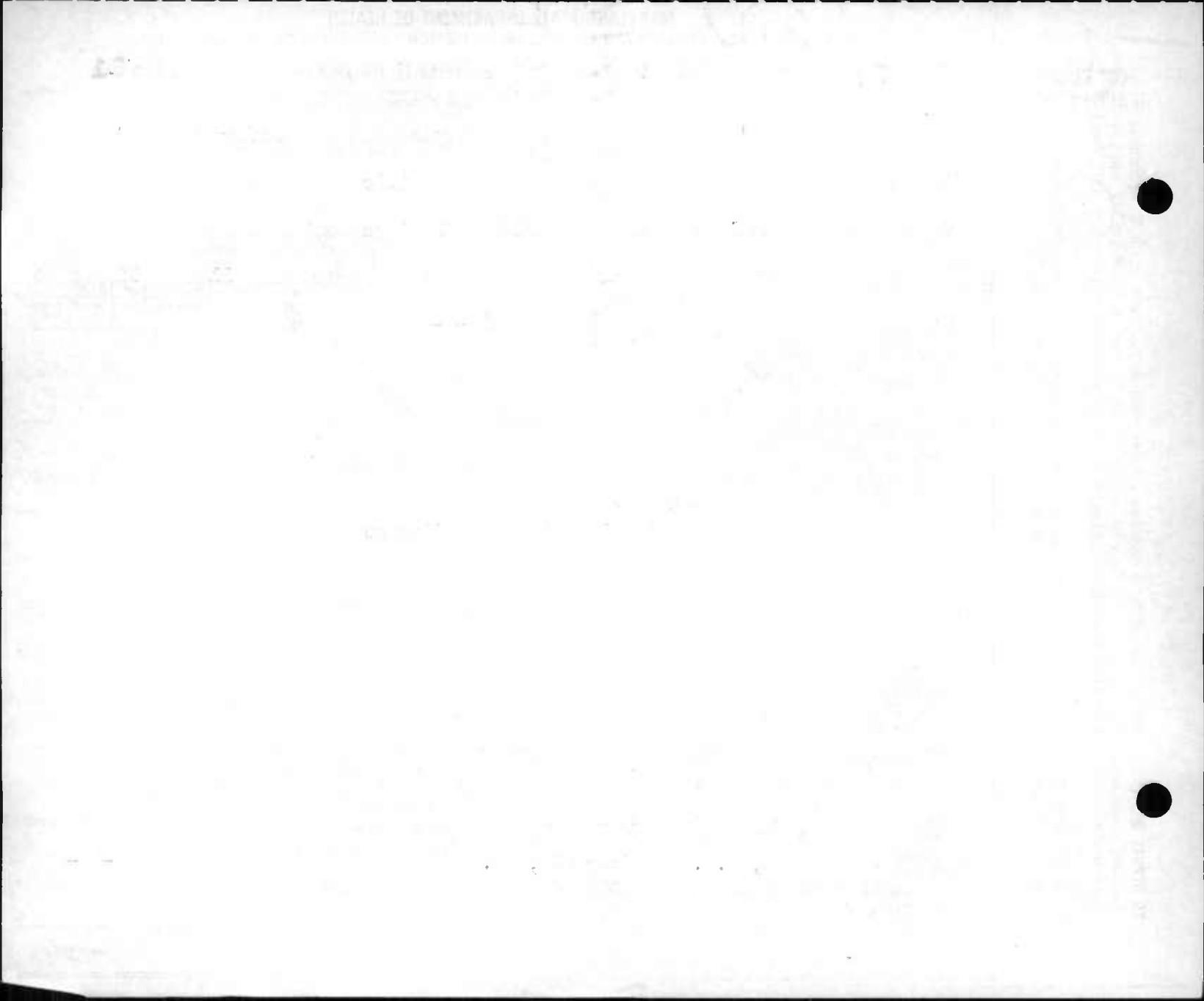
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

15870		15861	
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 hrs</b>		b. COUNTY <b>Prince George's</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Alice Jones</b>		4. DATE OF DEATH Month Day Year <b>11 12 19 67</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <b>WIDOWED</b>		8. NEVER MARRIED <b>Divorced</b>	
9. AGE (In years lost birthday) <b>66 yrs.</b>		10. DATE OF BIRTH <b>12-7-1900</b>	
11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Lemos</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Bryant</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>1</b>	
17. INFORMANT <b>Ernest David Jones, Prince Edward, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ lost. (c) _____ INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Kehoe</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		22. DATE SIGNED <b>11-13-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 15, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Ashley Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Raretown, Calvert Co., Md.</b>	
24. FUNERAL DIRECTOR <b>G.O. Kirkness &amp; Sons of Republic, Inc.</b>		ADDRESS	
		25. RECEIVED BY REGISTRAR DATE <b>NOV 16 1967</b>	
		26b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												CERTIFICATE OF DEATH			15862		
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md						b. COUNTY 16-1					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			d. STREET ADDRESS 112 65th St. S.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7420 Marlboro Pike The Regent Nursing Home																	
3. NAME OF DECEASED (Type or print)		First Anastasios	Middle Karavangelos	Last	4. DATE OF DEATH NOV. 6 1967	Month Nov.	Day 6	Year 1967									
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/92	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Restaurant owner			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Greece			12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Marcos Karavangelos						14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT Anna Karavangelos same as #2			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> IMMEDIATE 4201 DUE TO (b) <u>Coronary artery disease</u> 4 yrs. DUE TO (c) <u>Advanced A.S.C.V.D.</u>												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>July, 1961</u> , to <u>Nov. 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 4, 1967</u> , and that death occurred at <u>7:00 PM</u> , from causes and on the date stated above.																	
22a. SIGNATURE <u>F. Joseph Weber</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED Nov. 6, 67					
22c. PHYSICIAN'S NAME (Type) <u>F. JOS. WEBER</u>			22d. ADDRESS 3230 PENNA. AVE, SE.														
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 11/9/67			23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery			23d. LOCATION (City or Town) Washington, D.C.			(County) (State)					
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.						25a. REC'D BY REGISTRAR DATE NOV 9 1967			25b. REGISTRAR'S SIGNATURE Charles Judge								



## MARYLAND STATE DEPARTMENT OF HEALTH

15870 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15863

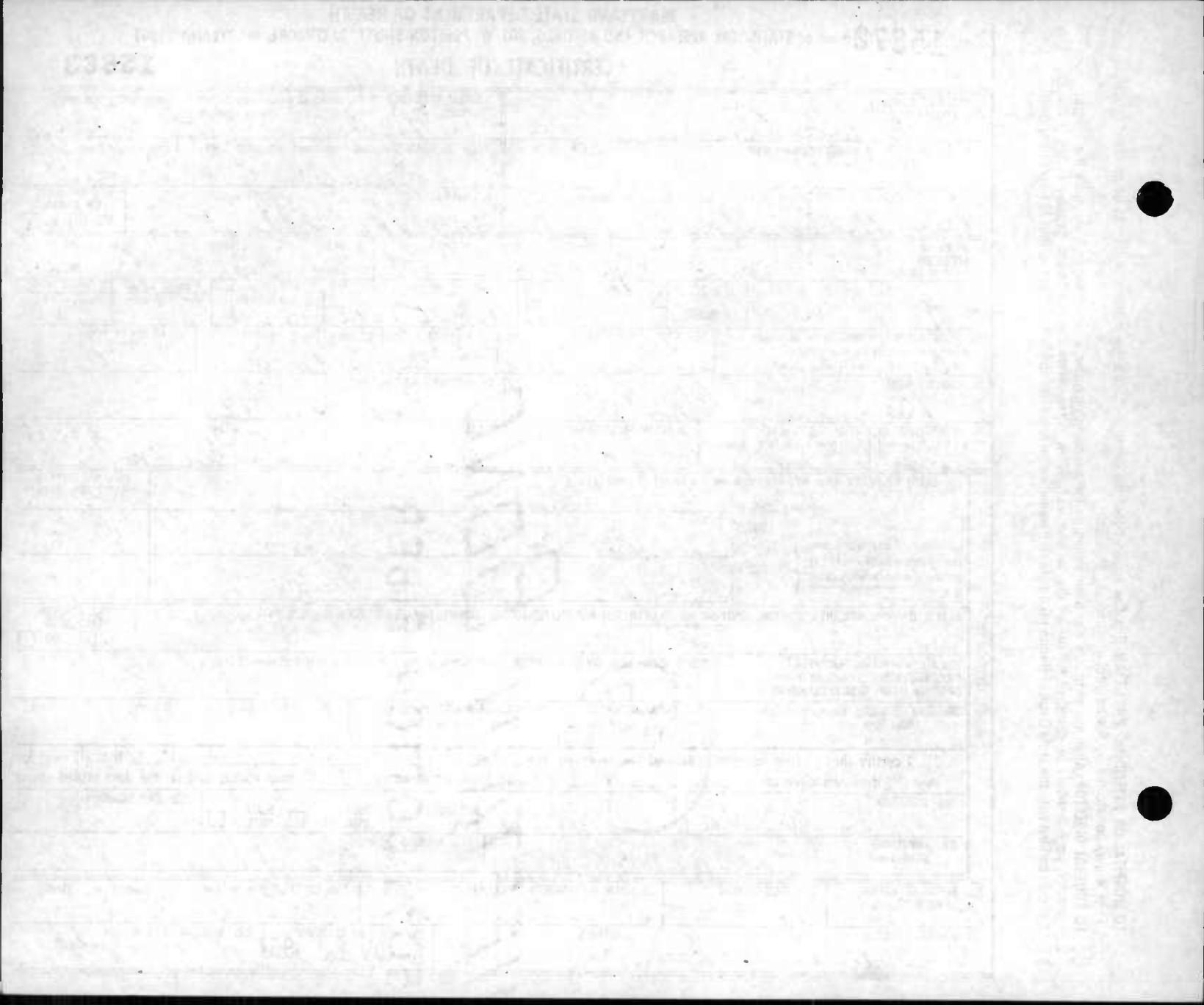
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>323 Main Street</i>		d. STREET ADDRESS <i>323 Main Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>FLORENCE</i>	Middle <i>Myrtle</i>	Last <i>KELLER</i>
4. DATE OF DEATH Month <i>Mar</i>	Month <i>6</i>	Day <i>19</i>	Year <i>67</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 5 1912</i>
9. AGE (In years last birthday) <i>55 yrs.</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS. Days <i>23</i>	12. IF UNDER 24 HRS. Hours <i>Main street</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Co-owner news agency</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>newspaper</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Benjamin Beall</i>	14. MOTHER'S MAIDEN NAME <i>Eva Smith</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No</i>	
16. SOCIAL SECURITY NO. <i>3 23 54</i>	17. INFORMANT <i>C. R. Keller</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Hyperlipidemia</i>	DUE TO <i>Hyperlipidemia</i>	INTERVAL BETWEEN ONSET AND DEATH <i>18 yrs</i>	
(b) DUE TO <i>Hyperlipidemia</i>	(c) <i>Hyperlipidemia C-V-R-His.</i>	5 yrs 16 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Mild diabetic tix</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>2/17/67</i> to <i>7/16/67</i> , that (I) (we) last saw the deceased alive on <i>11/6/67</i> and that death occurred at <i>30</i> M, from causes and on the date stated above.	22b. DATE SIGNED		
22a. SIGNATURE <i>J M Warren</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>J M Warren</i>	22d. ADDRESS <i>Laurel Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11-9-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>St Mary's Cem</i>	23d. LOCATION (City or Town) (County) (State) <i>Laurel Md.</i>
24. FUNERAL DIRECTOR <i>De Witt Danoldson</i>	25a. REC'D BY REGISTRAR DATE <i>NOV 13 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15873

**CERTIFICATE OF DEATH**

15864

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in, and signed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> 22 days		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>	
3. NAME OF DECEASED First <b>James</b> Middle <b>B</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pastored</b>		8. DATE OF BIRTH <b>11 June 1910</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		9. AGE (In years lost birthday) <b>57 yrs.</b>	
13. FATHER'S NAME <b>James B. Kessler</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Wash., D.C.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO. <b>577-22-0545</b>		17. INFORMANT Address <b>Mrs. Faith M. Kessler (above address)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>576X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>18 days</b>	
Acute Peritonitis		<b>5 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>the hospital</del> attended the deceased from <b>Nov. 22, 1967</b> , to <b>Nov. 22, 1967</b> , that (I) <del>saw</del> last saw the deceased alive on <b>Nov. 22, 1967</b> , and that death occurred at <b>5:40 AM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>Nov. 22, 1967</b>	
22a. SIGNATURE <i>Samuel Sugar</i>		22d. ADDRESS <b>4637 Eastern Ave. Washington, D.C. 20018</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel Sugar, M.D.</b>		22e. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/25/67</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		25a. ADDRESS <b>Mt. Rainier, Maryland</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
		25c. REC'D BY REGISTRAR DATE <b>NOV 27 1967</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

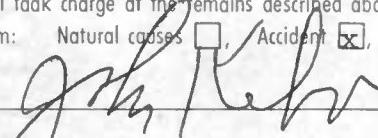
15874  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15865

FOR STATE  
HEALTH DEPT.

If any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with  
form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b> 16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>4504 Knox Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Lloyd Alexander Kessler</b>		4. DATE OF DEATH Month <b>11 17 1967</b>	Doy Year		
S. SEX <b>male</b>	First <b>white</b>	Middle <b>Kessler</b>	Lost		
6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>1-17-07</b>	9. AGE (In years last birthday) <b>60 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Groundsman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U of Maryland</b>	11. BIRTHPLACE (State or foreign country) <b>Prince George, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Clarence S. Kessler</b>	14. MOTHER'S MAIDEN NAME <b>Agnes C. Woodward</b>	Address <b>6737 Riverdale Road Riverdale, Md.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>561 48 5705</b>	17. INFORMANT <b>Charles R. Kessler</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO <b>8124</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost. (c)	INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>pedestrian struck by car</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>8:30pm p.m. 11-17 1967</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>2</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Route 1</b>	20f. (City or town) <b>College Park</b>	(County) <b>P.G.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED <b>11-18-67</b>		
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/22/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) <b>Colmar Manor, P.G.</b>	(County) <b>Md.</b>	(State)
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>	ADDRESS	25a. REC'D BY REGISTRAR <b>NOV 22 1967</b>	25b. REGISTRAR'S SIGNATURE 		

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11640-70-3754-1193-1 SEMI-AUTOMATIC

Document 2000

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PAN-3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

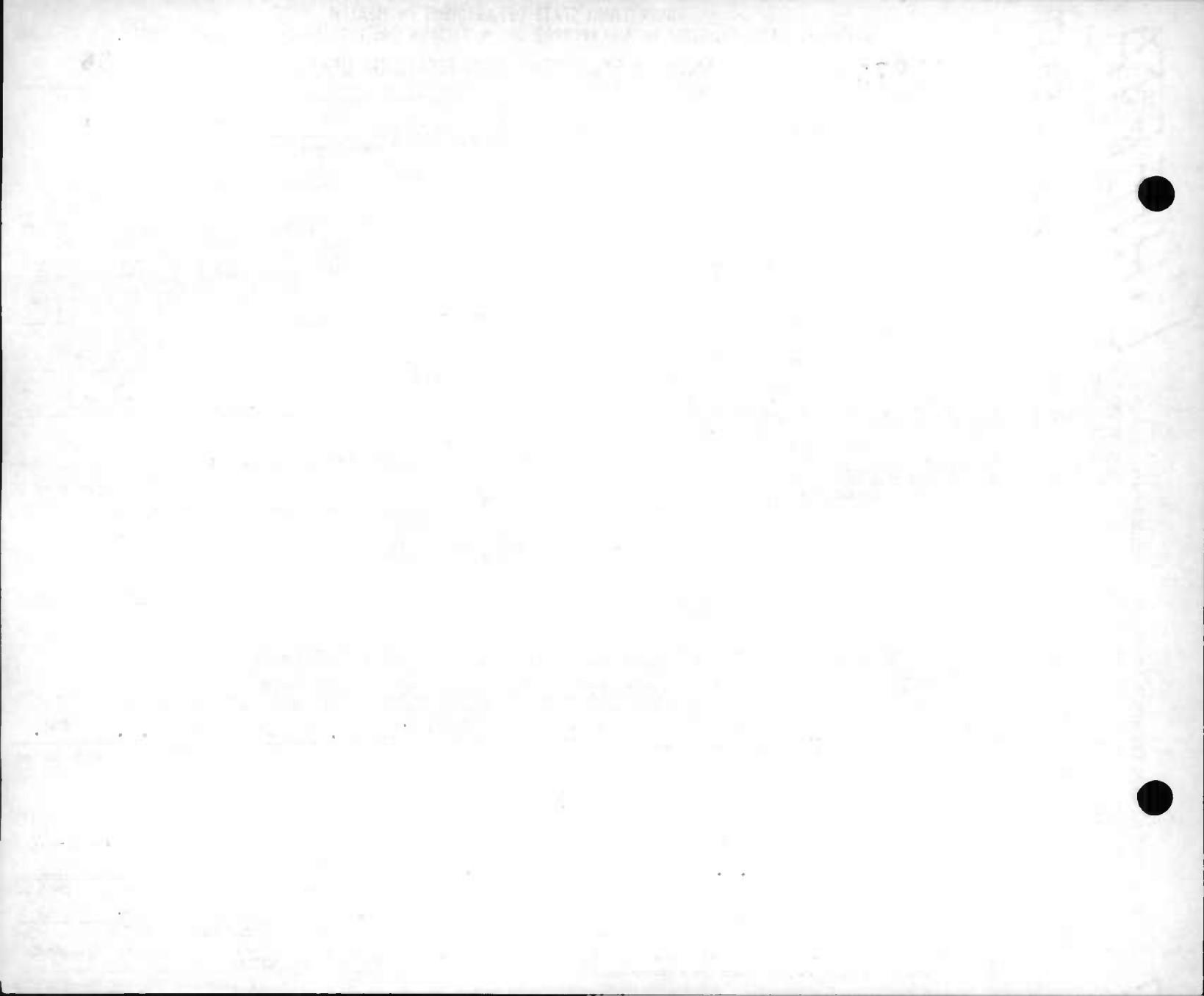
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15875

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15866

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb six days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 1019 8th Street	
3. NAME OF DECEASED (Type or print) Michael Stanton Keys		First Last	4. DATE OF DEATH 11 11 19 67
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2-14-49		9. AGE (In years last birthday) 18 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY high school	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Kehoe George Keys		14. MOTHER'S MAIDEN NAME Gwendaline Harriett Hayes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 17. INFORMANT Kehoe Keys Address Arlene	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO 8254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma - auto accident DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH six days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) passenger in car involved in accident	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 11-5 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4900 Powdermill Rd. Beltsville P.G. Md.
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-14-67	23c. NAME OF CEMETERY OR CREMATORIAL Any Hill Cemetery Laurel Md
24. FUNERAL DIRECTOR De Witt Danaedan, Laurel, Md.		ADDRESS	23d. LOCATION (City or Town) (County) (State) Laurel Md
		25a. REC'D. BY REGISTRAR NOV 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
		DATE	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

15876

15867

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanham</i> c. LENGTH OF STAY IN 1b <i>8 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i> 161	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Magnolia Gardens Nursing Home</i>		d. STREET ADDRESS <i>5600 - 54<sup>th</sup> Ave. apt. 619</i>	
3. NAME OF DECEASED (Type or print)	First <i>Margaret</i>	Middle	Last <i>Kircher</i>
4. DATE OF DEATH Month <i>Nov</i> Day <i>1</i> Year <i>1967</i>	5. SEX <i>femail</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Apr. 2, 1881</i>	9. AGE (In years last birthday) <i>86 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Germany</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	12. CITIZEN OF WHAT COUNTRY? <i>G.S.</i>	13. FATHER'S NAME <i>UNKNOWN</i>	14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>070 38 2507</i>	17. INFORMANT <i>WILLIAM KIRCHER JR.</i>	Address <i>5600 54<sup>th</sup> Ave Riverdale, Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardi thrombo</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>	
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>paroxysia</i>		16 hours	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>arteriosclerosis</i>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) <i>injury occurred</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10/24/67</i> , 19, to <i>11/1/67</i> , 19, that (I) (we) last saw the deceased alive on <i>11/1/67</i> , 19, and that death occurred at <i>12:00 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Leon Levitsky</i>		22b. DATE SIGNED <i>11-1-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>LEON LEVITSKY</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>3408 R.I. AVE MT. RAINIER, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>6 Nov. 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>MARPLE GROVE MEMORIAL PK.</i>	23d. LOCATION (City, town or county) (State) <i>KEW GARDENS L.I. NY</i>
24. FUNERAL DIRECTOR <i>WW CHAMBERS CO</i>	ADDRESS <i>RIVERDALE, MD.</i>	25a. REC'D BY REGISTRAR <i>NOV 3 1967</i>	25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15877

CERTIFICATE OF DEATH

15868

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Mass. Ave. N.E. Wash. D.C.</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN lb <i>one year</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>		d. STREET ADDRESS <i>910 Mass. Ave. N.E.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hyattsville Nursing Home</i>				d. STREET ADDRESS <i>910 Mass. Ave. N.E.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Olive</i>		First	Middle	Lost	4. DATE OF DEATH <i>Knipe November 7 1967</i>	Month	Doy Year
S. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12-24-1885</i>	9. AGE (In years last birthday) <i>81 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Librarian - Library of Congress (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Norristown, Penn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Oliver Knipe</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Marjorie F. McNall-912 Elm Ave.</i>		Address <i>Takoma Park, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X</i>		DUE TO (b) <i>Carcinomatosis (General)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>last.</i>		DUE TO (c) <i>Carcinoma Breast (Primary)</i>		4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). <i>Atherosclerotic Heart Disease (16 years)</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>Nov. 7 1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1967</i> to <i>Nov 7 1967</i> , that (I) (we) last saw the deceased alive on <i>Oct 6 1967</i> and that death occurred at <i>1 P.M.</i> from causes and on the date stated above.							
22a. SIGNATURE <i>R.J. McNulty, M.D.</i>		M.D.	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <i>11-7-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>R.J. McNulty</i>		22d. ADDRESS <i>1016 E. CAPITOL ST. WASH. DC</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>11/9/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Glenwood Cemetery Washington, D.C.</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR <i>SHHINES Co. 2901 14th St. N.W. D.C.</i>		ADDRESS <i>Washington, D.C.</i>		25a. REC'D BY REGISTRAR <i>NOV 10 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

(bottom)

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15878

## CERTIFICATE OF DEATH

Item #1 Film G395 11/21/67 KK

15869

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Dame George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Dame George</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN lb <i>5 mrs</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		d. STREET ADDRESS <i>4410 Oglethorpe St.</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>4110 Oglethorpe St. Apt. 717</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>ANTON</i>		First	Middle	Last	4. DATE OF DEATH <i>KOERBER</i>	Month <i>11</i>	Day <i>10</i>	Year <i>1967</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/13/1892</i>	9. AGE (In years last birthday) <i>75 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Frederick W Koerber</i>		14. MOTHER'S MAIDEN NAME <i>Weijan</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>571-40-4920</i>		17. INFORMANT <i>Rose Koerber. (daughter) as above</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>1992</i>		DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <i>Carcinoma of Prostate &amp; Bladder</i>		INTERVAL BETWEEN ONSET AND DEATH <i>-</i>				
IMMEDIATE CAUSE (e) <i>1992</i>		DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <i>Carcinoma of Prostate &amp; Bladder</i>		INTERVAL BETWEEN ONSET AND DEATH <i>-</i>				
DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <i>Carcinoma of Prostate &amp; Bladder</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5800 10th St</i>		20f. (City or town) (County) (State) <i>Hyattsville Md</i>		
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5800 10th St</i>		20f. (City or town) (County) (State) <i>Hyattsville Md</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>8/12</i> , 19 <i>67</i> to <i>11/10</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11/10</i> , 19 <i>67</i> , and that death occurred at <i>2:30</i> P.M. from the causes and on the date stated above.						22b. DATE SIGNED		
22c. SIGNATURE <i>John W Winkler Jr</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <i>John W WINKLER JR MD</i>				22d. ADDRESS <i>5800 10th St</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore Md</i>			
23e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/14/67</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore Md</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. K. Hünemann &amp; Son Funeral Home</i>		ADDRESS <i>5732 Georgia Ave NW</i>		25a. REC'D BY REGISTRAR <i>NOV 14 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

CONFIDENTIAL INFORMATION CONTAINED HEREIN  
HEREIN IS UNCLASSIFIED

NOV 20 1963

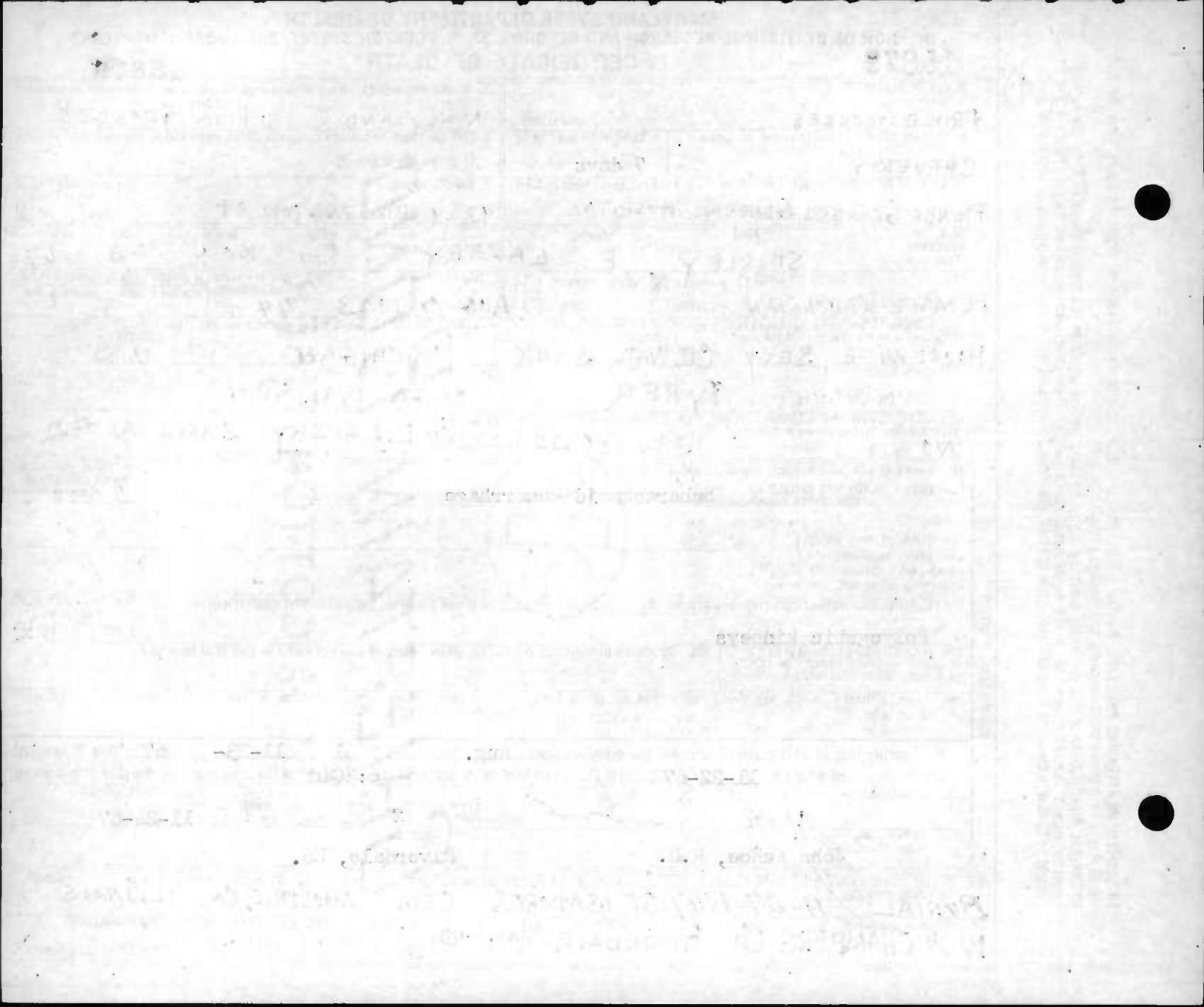
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b <b>7 days</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGES GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>SHIRLEY</b>		Middle <b>E.</b>		Last <b>LAVERY</b>		4. DATE OF DEATH <b>NOV 23 1967</b>	Month <b>NOV</b>	Day <b>23</b>	Year <b>1967</b>
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG 7 1923</b>		9. AGE (In years last birthday) <b>44 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE, SECY CIT. NATL BANK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE, SECY CIT. NATL BANK</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MICHIGAN</b>							
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>TYRER</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>384 12 8329</b>		17. INFORMANT <b>ROBERT E. LAVERY</b>		Address <b>SAME AS #2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b>											
330X DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)											
DUE TO (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Polycystic kidneys</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 19 61</b> , to <b>11-23-1967</b> , that (I) (we) last saw the deceased alive on <b>11-22-67</b> , 19 <b>61</b> , and that death occurred at <b>6:30 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE 		22b. DATE SIGNED <b>11-24-67</b>									
22c. PHYSICIAN'S NAME (Type) <b>John Kehoe, M.D.</b>		22d. ADDRESS <b>Riverdale, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-27-1967</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>ST. ISADORES CEM</b>		23d. LOCATION (City, town or county) <b>MOULTRIE, CO. ILLINOIS</b>		(State)			
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO</b>		ADDRESS <b>RIVERDALE, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>					
DATE				DATE							



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15880

15871

**CERTIFICATE OF DEATH**

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>		c. LENGTH OF STAY IN lb <b>12 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Southern Md. Medical Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>LAW</b>	4. DATE OF DEATH Month <b>11</b> Doy <b>17</b> Year <b>1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1881</b> / / yrs. 9. AGE (In years last birthday) <b>86</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Scotland</b>
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>No</b> -----		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address <b>Mr. Russell Buck-Upper Marlboro, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Obstruction Circulation Collapsed</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) DUE TO <b>due to Myocardial Infarction</b> lost. } (c) DUE TO <b>Arteriosclerotic CVD H.D.</b>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-6</b> , 19 <b>67</b> to <b>11-16</b> , 19 <b>67</b> , and that death occurred at <b>11-16</b> , 19 <b>67</b> , M, fram causes and on the date stoted above.			
22o. SIGNATURE <b>Alfred R. Lapan</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11/17/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Alfred R. Lapan</b>		22d. ADDRESS <b>Clinton, Maryland,</b>	
23o. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/20/67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>St. Thomas Cemetery</b>
23d. LOCATION (City or Town) <b>Croom</b>		(County) (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>		ADDRESS	25o. REC'D BY REGISTRAR DATE <b>NOV 22 1967</b>
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

1  
15881

**CERTIFICATE OF DEATH**

15872

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, from the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, from the funeral director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Geo.</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>			d. STREET ADDRESS <b>1011-East West Hwy.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Lawrence</b>	Middle <b>Bailey</b>	Last <b>Lipscomb</b>	4. DATE OF DEATH <b>November 4 1967</b>	Month Year	Day 19 Year 67
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/16/1912</b>	9. AGE (In years since birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS. DAYS <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Mechanic</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Wash., D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Theodric Lipscomb</b>			14. MOTHER'S MAIDEN NAME <b>Mary Hogan</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-10-5445</b>		17. INFORMANT <b>Mrs. Lillian M. Lipscomb (above address) (Wife) address</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Myocardial Infarction</b> INTERVAL BETWEEN DEATH AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 24, 1967</b> , to <b>Nov. 4, 1967</b> that (I) (we) lost saw the deceased alive on <b>Nov. 3, 1967</b> , and that death occurred at <b>10% M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Charles C. Hageage</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Charles C. Hageage</b>		22d. ADDRESS <b>3308 - Perry St., Mt. Rainier, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/8/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Prospect Hill Cem.</b>		23d. LOCATION (City or Town) <b>Wash., D.C.</b> (County) (State)	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

2782

2293

DATE 1980

DATA 1980

DATA 1980

TESTS AND TREATMENTS

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

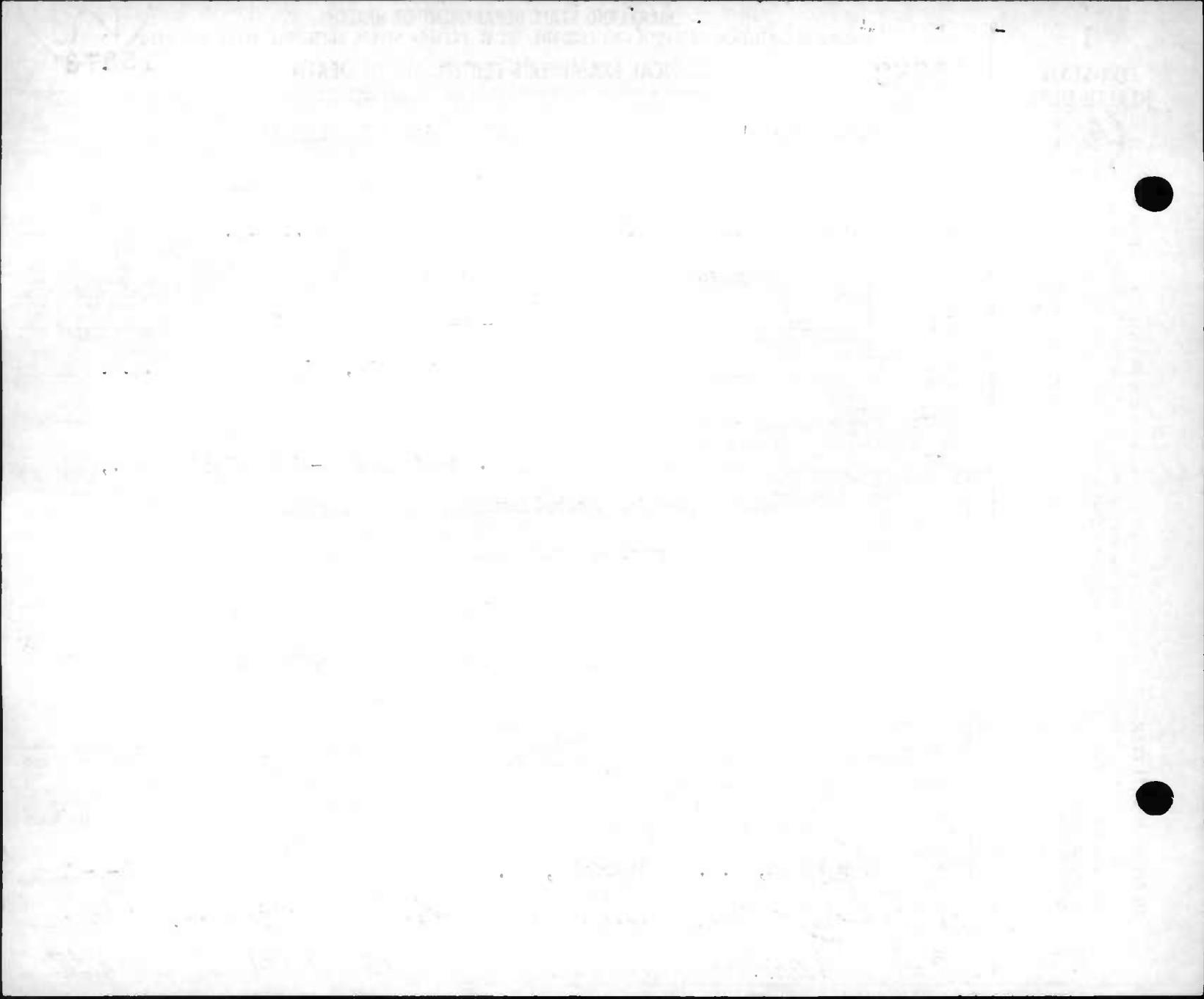
15873

FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Ring Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15882		99		15873			
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA		c. LENGTH OF STAY IN lb d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47-2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. STREET ADDRESS <b>1018 Florida Ave., N.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Abraham</b>		First	Middle	Lost	4. DATE OF DEATH <b>Locke</b> 11 7 19 67		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-1914</b>		9. AGE (In years lost birthday) <b>53</b> YRS.	IF UNDER 1 YEAR Months <input type="checkbox"/> Dofs <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>FEBRUARY 14, 1914</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JESSE LOCKE</b>		14. MOTHER'S MAIDEN NAME <b>AMELIA COX</b>		Address <b>Mr. Archie Locke - 1018 Florida Ave., NE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b> <b>NONE</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Archie Locke - 1018 Florida Ave., NE</b>		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Alcoholism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) <b>Exposure to cold</b> DUE TO (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED <b>11-9-67</b>	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		EXAMINER'S NAME (Type) <b>Riverdale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial - 11-15-67</b>		23b. DATE THEREOF <b>11-15-67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Lincoln Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Southland, Md.</b>	
24. FUNERAL DIRECTOR <b>John T. Phinney</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>Charles Juge</b>		25b. REGISTRAR'S SIGNATURE	
VR A15ME (5) 6M 1/66		DATE <b>NOV 13 1967</b>					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15883

CERTIFICATE OF DEATH

15874

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH <b>COUNTY PRINCE GEORGES</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b>		b. COUNTY <b>(C.G.B.)</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>		d. STREET ADDRESS <b>5204 CANTERBURY WAY</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MALCOLM GROW USAF HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16-1		
3. NAME OF DECEASED (Type or print) <b>WILLIAM GEORGE LOONEY</b>		First	Middle	Lost	4. DATE OF DEATH <b>NOVEMBER 2 19 67</b>	Month	Doy	Year
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 Oct 1922</b>	9. AGE (In years lost birthday) <b>45 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USAF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USAF</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW HAVEN, CONN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>WILLIAM CHARLES LOONEY</b>				14. MOTHER'S MAIDEN NAME <b>MARY BURRAGE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>JUL 42-JUL 63</b>		17. INFORMANT <b>WIFE</b>		Address <b>SAME AS #2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>241X</b> <i>Gastroenteritis secondary (obstructive)</i> 12 hours DUE TO <i>Asthma</i> years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Asthma</i> DUE TO (c) <i>Acute Myocardial infarction and pulmonary edema</i> 1 month								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>XIX</b> (this hospital) attended the deceased from <b>80ct 19 67</b> , to <b>2 Nov 19 67</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>2 NOVEMBER 67</b> , and that death occurred at <b>1:20M</b> , from causes and on the date stated above.								
22a. SIGNATURE <i>Allen D. Ward</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Nov 2 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>ALLEN D. WARD, CAPT, USAF, MC</b>		22d. ADDRESS <b>Malcolm Grow USAF Hospital Andrews AFB, Wash, D.C. 20331</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/6/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>ARLINGTON CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>		
24. FUNERAL DIRECTOR <b>ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 7 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

15884		15875									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Susie	Middle Augusta	Last Love	4. DATE OF DEATH November 11, 1967	Month November	Day 11	Year 1967			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/82	9. AGE (in years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Andrew Hoskins											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 219-54-9649			17. INFORMANT Mrs. Naomi Houghton			6018 Mustang Drive Riverdale, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4330 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) Arterio-sclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 26 yrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at : AM, from the causes and on the date stated above.											
22a. SIGNATURE Peter Duus											
22c. PHYSICIAN'S NAME (Type) Peter Duus, M.D.		22d. ADDRESS 6124 Central Ave., Capitol Hgts., Md. 20027									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov. 14, 1967		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Glenwood Cemetery 843 Georgia Avenue		23d. LOCATION (City, town or county) Washington, D.C.		(State)			
24. FUNERAL DIRECTOR John Carter Warner E. Pumphrey, Inc.		ADDRESS 843 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR NOV 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					
DATE											



*2*  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**Items 13 & 17 Film G307 2/1/68**  
**CERTIFICATE OF DEATH**

15876

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Canada</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Toronto</b>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>1520 Danforth Ave.</b>								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Daisy</b>		First <b>Daisy</b>	Middle <b></b>	Last <b>Maginn</b>	4. DATE OF DEATH Month <b>Nov.</b> Day <b>21</b> Year <b>19 68</b>						
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>* * * * * 3-12-89</b>	9. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>England</b>			12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>				
13. FATHER'S NAME <b>Benjamin W. Whitworth</b>					14. MOTHER'S MAIDEN NAME <b>Emma Garner</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Gladys</b>			Address <b>Mrs. Kay Broom (daughter)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO <b>163X</b>										INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>CA OF RT LUNG. RLL</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 13</b> , 1967, to <b>Nov 21</b> , 1967, that (I) <b>last</b> saw the deceased alive on <b>Nov 21</b> , 1967, and that death occurred at <b>4:40 PM</b> , from causes and on the date stated above											
22a. SIGNATURE <b>Sydney Sodghian</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-21-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Sydney Sodghian</b>		22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-21-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Pine Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Toronto Canada</b>					
24. FUNERAL DIRECTOR <b>Robert J. DeWitt</b>		ADDRESS <b>Box 1195</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					
VR A15 (4) 25M 1/67		Falls Church, Va.		DATE <b>NOV 24 1967</b>							

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## MARYLAND STATE DEPARTMENT OF HEALTH

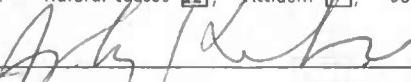
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items 11, 12, 13 & 14 Film G395 11/21/67

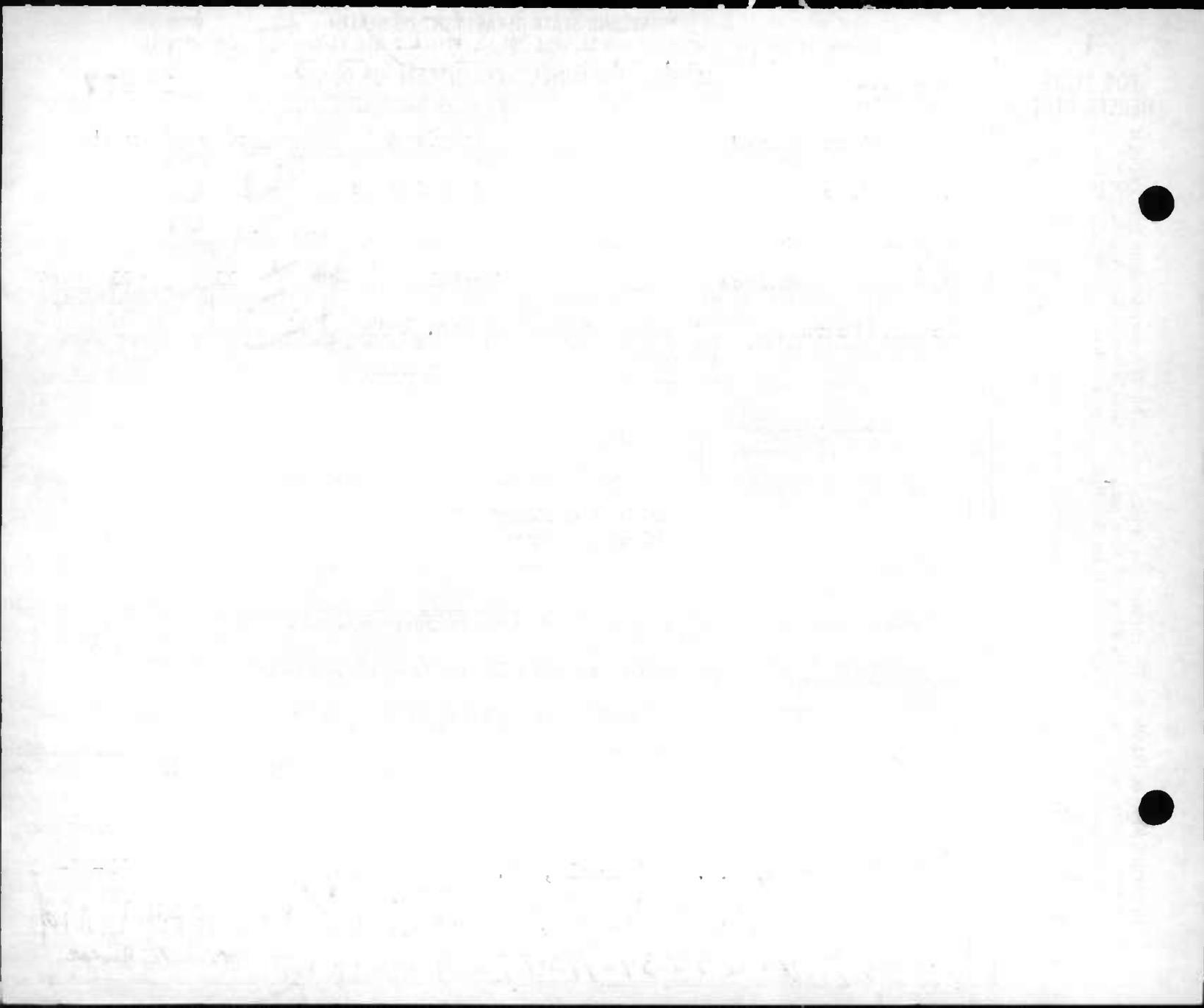
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15086		15877	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchelville</b>		c. LENGTH OF STAY IN lb <b>1b</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 1050 Woodmore Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Wallace</b>		<b>First</b> <b>Marshall</b>	<b>Middle</b> <b>Lost</b> <b>Month</b> <b>Year</b> <b>11</b> <b>11</b> <b>19</b> <b>67</b>
<b>4. DATE OF DEATH</b> <b>20 Jan. 1933</b>	<b>8. DATE OF BIRTH</b> <b>34 yrs.</b>	<b>9. AGE (in years lost birthday)</b> <b>34 yrs.</b>	<b>IF UNDER 1 YEAR</b> <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Male</b> <b>Negro</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>
<b>13. FATHER'S NAME</b> <b>Curtis Marshall</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Nettie Hawkins</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Intestinal obstruction</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5703</b> <b>days</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)</b> <b>Volvulus of cecum</b> <b>DUE TO</b> <b>lost.</b> <b>DUE TO</b> <b>(c)</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)</b>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. <b>p.m.</b> <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> 		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>Address (Street, city, town, or county)</b> <b>John Kehoe, M.D. Riverdale, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>11-15-67</b>		<b>23b. DATE THEREOF</b> <b>11-15-67</b>	<b>23c. NAME OF CEMETERY OR CREMATORIAL</b> <b>Holy Family</b>
<b>24. FUNERAL DIRECTOR</b> <b>Rollins J. Home 4339-Aunt PLH</b>		<b>ADDRESS</b> <b>NOV 16 1967</b>	<b>25a. REC'D BY REGISTRAR</b> <b>NOV 16 1967</b>
			<b>25b. REGISTRAR'S SIGNATURE</b> <b>John Kehoe, M.D.</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

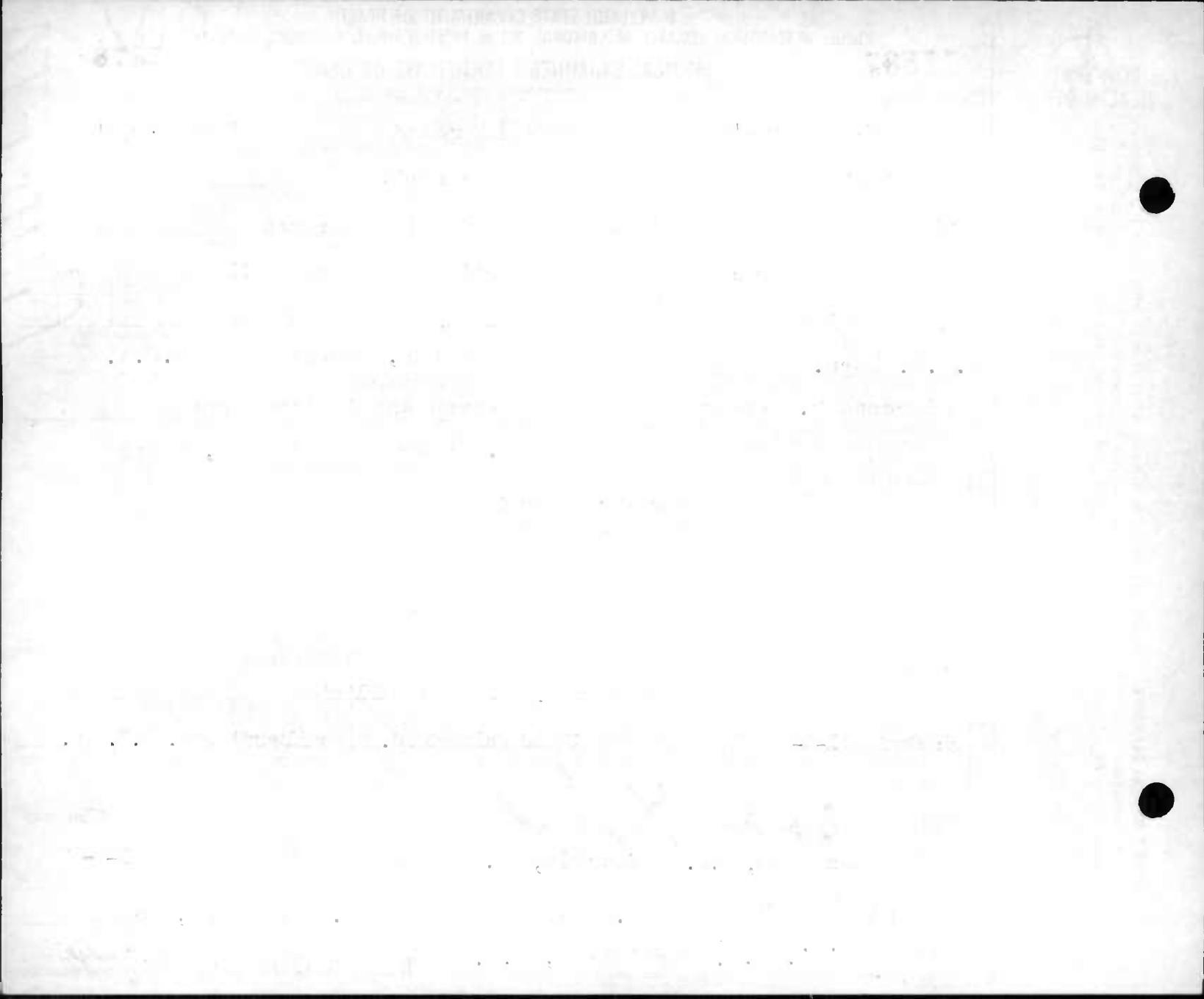
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>		16/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>			d. STREET ADDRESS <b>8555 Glen Dale Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Laurie</b>	Middle <b>C</b>	Last <b>Martin</b>	4. DATE OF DEATH 11	Month 8	Day 19	Year 67
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1908</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.C.A. Corp.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Topeka, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence H. Martin</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Antoinette Stanton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Baker</b>		Address <b>El Paso, Texas</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO <b>Trauma auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO _____ last. (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car involved in collision</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>5:00 p.m. 17-8-1967</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Old Calvert Rd. &amp; Kenilworth Ave. P.G. Co.</b>	20f. (City or town) <b>P.G. Co.</b>	(County) <b>P.G. Co.</b>	(State) <b>P.G. Co.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED <b>11-9-67</b>
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					Address (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE THEREOF <b>11/10/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Bliss National Cem. El Paso, Texas</b>	23d. LOCATION (City or Town) (County) (State) <b>El Paso, Texas</b>			
24. FUNERAL DIRECTOR <b>The S.H. Hines Company</b>		ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>	25a. REC'D BY REGISTRAR DATE <b>NOV 10 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH

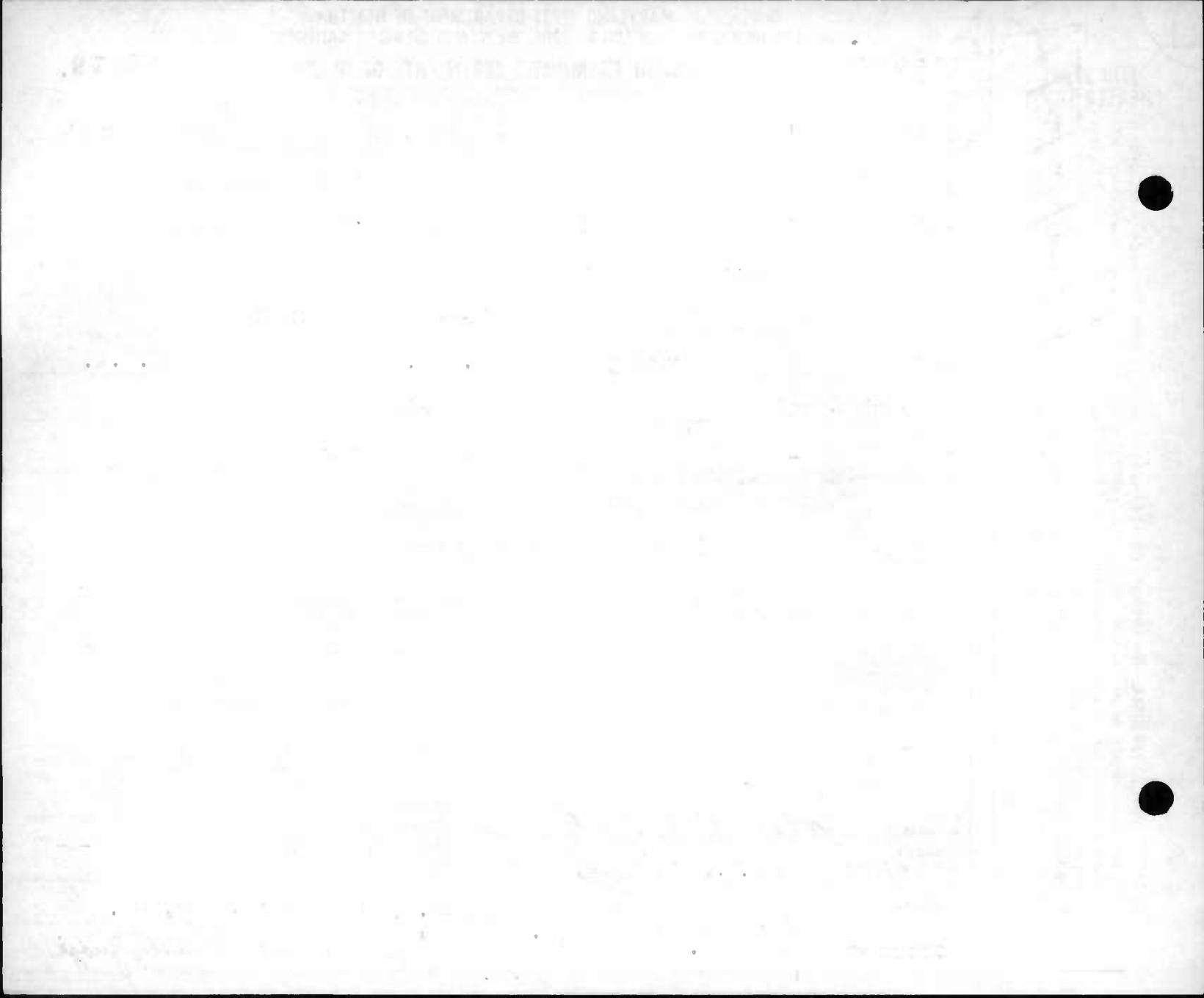
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

1  
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH					15879				
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>DOA</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>					d. STREET ADDRESS <b>3612 41st Avenue</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First <b>Larry</b>	Middle <b>Peter</b>	Last <b>Mayola</b>	4. DATE OF DEATH	Month <b>11</b>	Doy <b>6</b>	Year <b>1967</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-2-7</b>	9. AGE (In years last birthday) <b>1059 yrs.</b>	IF UNDER 1 YEAR Months <b>10</b>	IF UNDER 24 HRS. Dys <b>59</b>	Hours Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Mayola</b>					14. MOTHER'S MAIDEN NAME <b>Maria Kelly</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>- - -</b>		17. INFORMANT <b>Hospital Records</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ulceration of multiple Hemangiomas of oesophagus</b> DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>John Kehoe</i> M.D. EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)									
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/9/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cem.</b>		23d. LOCATION (City or Town) <b>Colmar Manor, Md.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b> Maryland		25. REC'D BY REGISTRAR DATE <b>NOV 10 1967</b>		26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
VR A15ME (5) 6M 1/66									



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4** may be retained by the hospital or offending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #11 infor, taken from birth cert. ph

15885 Item #11 infor, taken from birth cert. ph  
15880

CERTIFICATE OF DEATH

1. PLACE OF DEATH Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 8 hrs. 10mins					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Baby Girl "B" McCulloch		4. DATE OF DEATH Nov. 5, 1967 Month Doy Year Nov. 5, 1967 IF UNDER 1 YEAR Months Days Hours Min. 8 10					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH Nov. 5, 1967		9. AGE (In years lost birthday) yrs. 16					
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) Cheverly, P.G. Co.					
13. FATHER'S NAME Robert Hill McCulloch		14. MOTHER'S MAIDEN NAME Honna Edith Seversance Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.					
17. INFORMANT							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Prematurity Atelectasis of lungs, bilateral. INTERVAL BETWEEN ONSET AND DEATH less than 1 day					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (physician) attended the deceased from Nov. 5, 1967, to Nov. 5, 1967, that (I) (xx) last saw the deceased alive on Nov. 5, 1967, and that death occurred at 5:55 PM, from causes and on the date stated above.				22b. DATE SIGNED 11-5-67			
22c. PHYSICIAN'S NAME (Type) Andrew G. Aronfy, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 6803 Good Luck Rd., New Carrollton, Md.				
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF 11-11-67	23c. NAME OF CEMETERY OR CREMATORIAL Prince George's General		23d. LOCATION (City or Town) Cheverly, Md. (County) (State)		
24. FUNERAL DIRECTOR William A. Parker		25a. REC'D BY REGISTRAR NOV 14 1967 DATE		25b. REGISTRAR'S SIGNATURE John J. Murphy			

1000' above sea level

1000' above sea level

1000' above sea level

Steeply dipping bedrock

steeply dipping

Indirect information: sand

continues "N" 1-2 miles

Wetland area

Glaciated

Glaciated

1000' above sea level

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

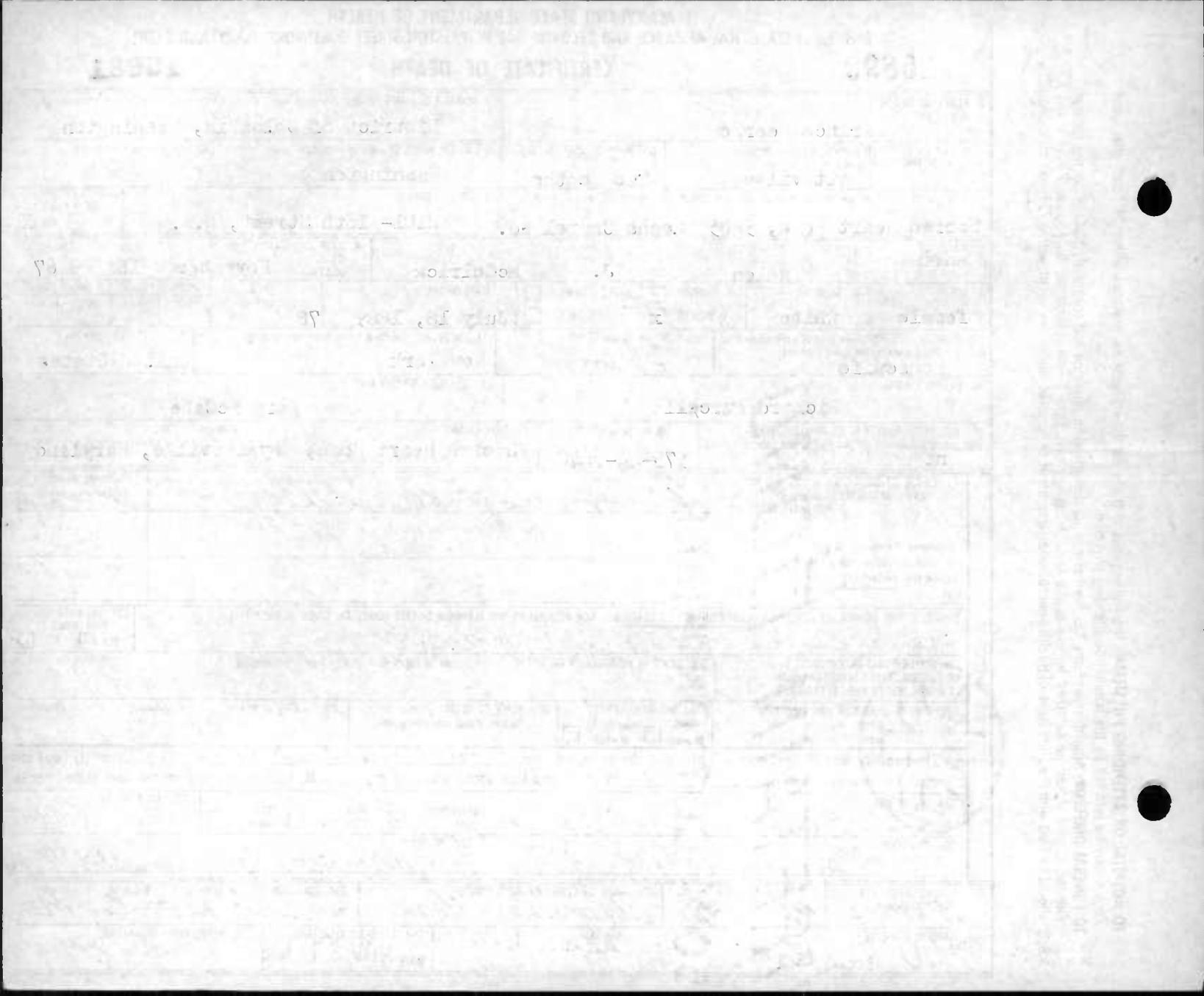
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

15890 15881

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia, Washington</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>Two months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Home, 5805 Queens Chapel Rd</b>				d. STREET ADDRESS <b>2101-16th Street, N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				e. DATE OF DEATH Month November Day 18 Year 1967			
3. NAME OF DECEASED (Type or print) <b>Helen</b>		First	Middle	Last	4. DATE OF DEATH Month November Day 18 Year 1967	Month November Day 18 Year 1967	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1889</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>47 House</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
13. FATHER'S NAME <b>Richard Purcell</b>				14. MOTHER'S MAIDEN NAME <b>Mary McCabe</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <b>No</b> <i>Navy</i>			16. SOCIAL SECURITY NO. <b>579-44-9640</b>		17. INFORMANT <b>Sacred Heart Home, Hyattsville, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause (last) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized arteriosclerosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT 18, 1967</b> , to <b>NOV 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>NOV 17, 1967</b> , and that death occurred at <b>10:30 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Pauline Devore</b>				M.D. ATTENDING PHYS.		22b. DATE SIGNED <b>Nov 18, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Pauline Devore, M.D.</b>				22d. ADDRESS <b>3415 Harrison St Hyattsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/21/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Washington Nec</b>		23d. LOCATION (City or Town) (County) (State) <b>Burial, Petcocks, MD.</b>	
24. FUNERAL DIRECTOR <b>W.H. Chambers Inc.</b>		ADDRESS <b>1400 Chapin St. N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

15882

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN lb <b>3 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>District Heights</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>7422 Marbury Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mark</b>		First <b>IX J.</b> Middle <b>McNally</b> Last	4. DATE OF DEATH <b>Nov. 23, 1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Month <b>Nov.</b> Month <b>23,</b> Doy <b>19</b> Year <b>67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NA</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>	9. AGE (In years last birthday) — yrs. IF UNDER 1 YEAR Months <b>19</b> IF UNDER 24 HRS. Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William P. McNally</b>		14. MOTHER'S MAIDEN NAME <b>Susan C. Martin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>William McNally Same As #2</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple acute gastric ulcers with hemorrhage;</b> INTERVAL BETWEEN ONSET AND DEATH <b>7640</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Acute pseudo-membranous enterocolitis.</b> DUE TO (c)			
2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>19</b> , to <b>Nov. 23, 1967</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Nov. 23, 1967</b> , and that death occurred at <b>4:25A</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Kelvin Minchin</i>		22b. DATE SIGNED <b>Nov. 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Kelvin Minchin, M.D.</b>		22d. ADDRESS <b>6400 Marlboro Pike, SE, Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/25/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Resurrection Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Clinton, PG Maryland</b>		23e. RECD BY REGISTRAR ADDRESS <b>ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND</b>	
24. FUNERAL DIRECTOR ADDRESS <b>ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE DATE <b>NOV 30 1967</b> <i>Charles Judge</i>	

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and we are going to work on the new one

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

2  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH						15883			
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>			b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>			d. STREET ADDRESS <b>3602 Hamilton Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
99 3. NAME OF DECEASED (Type or print)		First <b>Norman</b>	Middle <b>Henry</b>	Last <b>Mihill</b>	4. DATE OF DEATH <b>11 19 1967</b>	Month Day Year			
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-1917</b>	9. AGE (In years last birthday) <b>50 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done despite lack of working at the time of death) <b>Radio &amp; T.V. Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>			
13. FATHER'S NAME <b>Roy E. Mihill</b>			14. MOTHER'S MAIDEN NAME <b>Lila M. Hewitt</b>			Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> ) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>578 05 5623</b>		17. INFORMANT <b>Blanche E. Mihill Same as #2 (wife)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 4200 DUE TO <b>Arteriosclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)						unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> Not While <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i> M.D.						22. DATE SIGNED <b>11-20-67</b>			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		Address (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/22/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>George Washington</b>		23d. LOCATION (City or Town) <b>Hyattsville P.G.</b>		(County) (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>NOV 24 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

( ) and enclosed in a box. See also

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN lb <b>16 days</b>	b. COUNTY <b>Prince George's</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>		16-1				
3. NAME OF DECEASED (Type or print) <b>Bee A. Moores</b>	First	Middle	4. DATE OF DEATH <b>November 21, 1967</b>				
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WOOED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/6/81</b>	9. AGE (In years lost birthday) <b>86</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Hours <b>0</b>	Year Min. <b>0</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>church</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alex Moores</b>			14. MOTHER'S MAIDEN NAME <b>Nancy Ashby</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219 54 8045</b>		17. INFORMANT <b>Mollie E Moores</b>		Address <b>Greenbelt, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Undetermined.</b>							INTERVAL BETWEEN ONSET AND DEATH
7955 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ (c) _____							DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>p.m.</b> 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Seal</b> (County) <b>MD</b> (State)	
21. I certify that (I) <input type="checkbox"/> attended the deceased from <b>Nov. 21, 1967</b> to <b>Nov. 21, 1967</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>Nov. 21, 1967</b> , and that death occurred at <b>2:05 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>William C. Weintraub</i>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>William C. Weintraub, M. D.</b>		22d. ADDRESS <b>Professional Bldg., Greenbelt, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 24, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>NOV 27 1967</b>	
VR A15 (4) 25M 1/67							



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

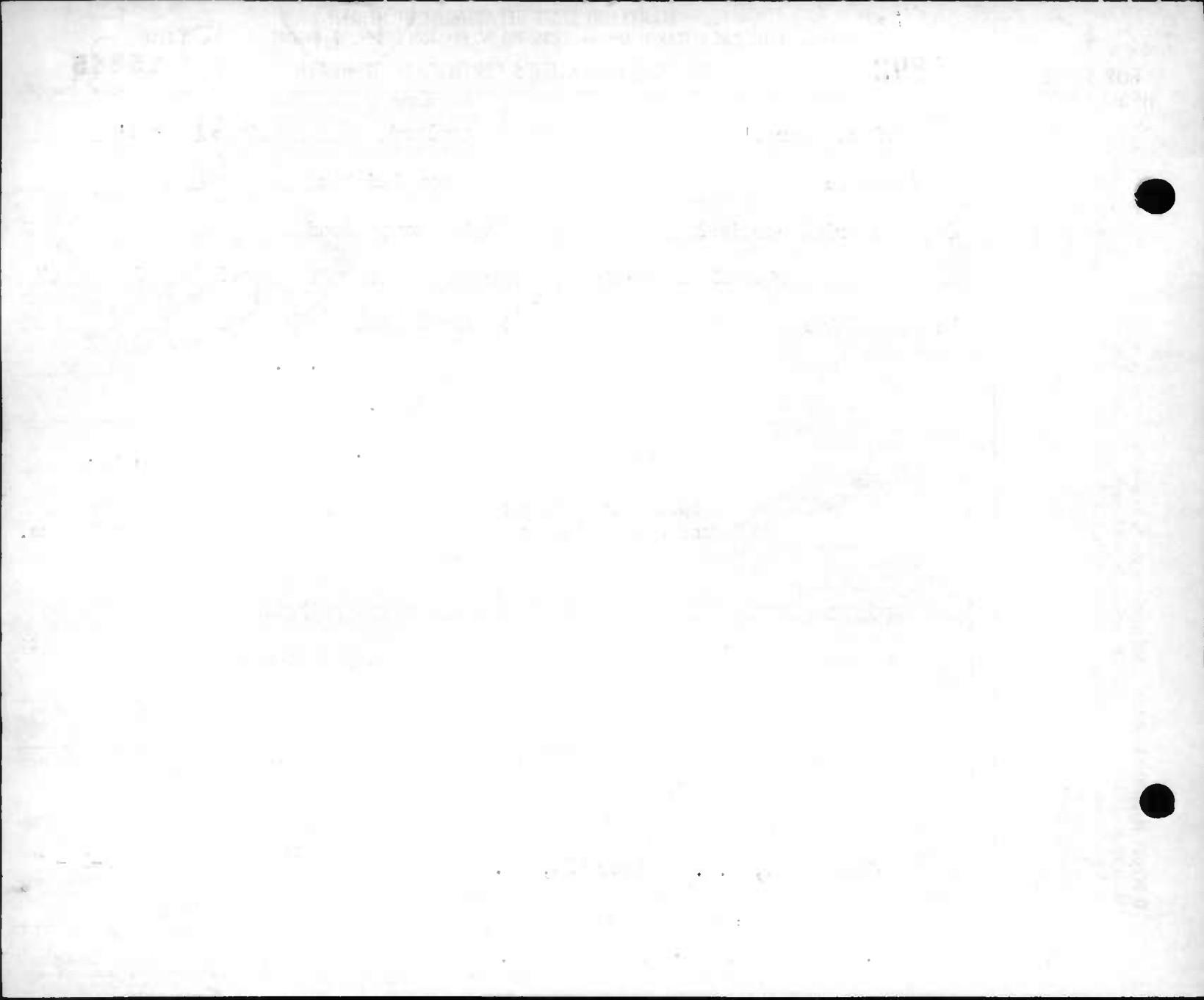
2  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 24 hours after death.

15893

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15885

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	c. LENGTH OF STAY IN lb <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berwyn Heights</b>	d. STREET ADDRESS <b>5928 Berwyn Road</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Michael</b>	Middle <b>David</b>	Last <b>Morgan</b>
4. DATE OF DEATH <b>11 13 19 67</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>16 April 1944</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		9. AGE (In years last birthday) <b>23 yrs.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>	
13. FATHER'S NAME <b>David B Morgan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>David B Morgan</b>		Address <b>Berwyn Heights, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____ stating the underlying cause (c) _____		INTERVAL BETWEEN ONSET AND DEATH weeks <b>over 20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>John Kehoe</i> M.D.	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 16, 1967</b>	23c. NAME OF CEMETERY OR OTHER <b>Arlington National Cemetery</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>
		25a. REC'D BY REGISTRAR DATE <b>NOV 17 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

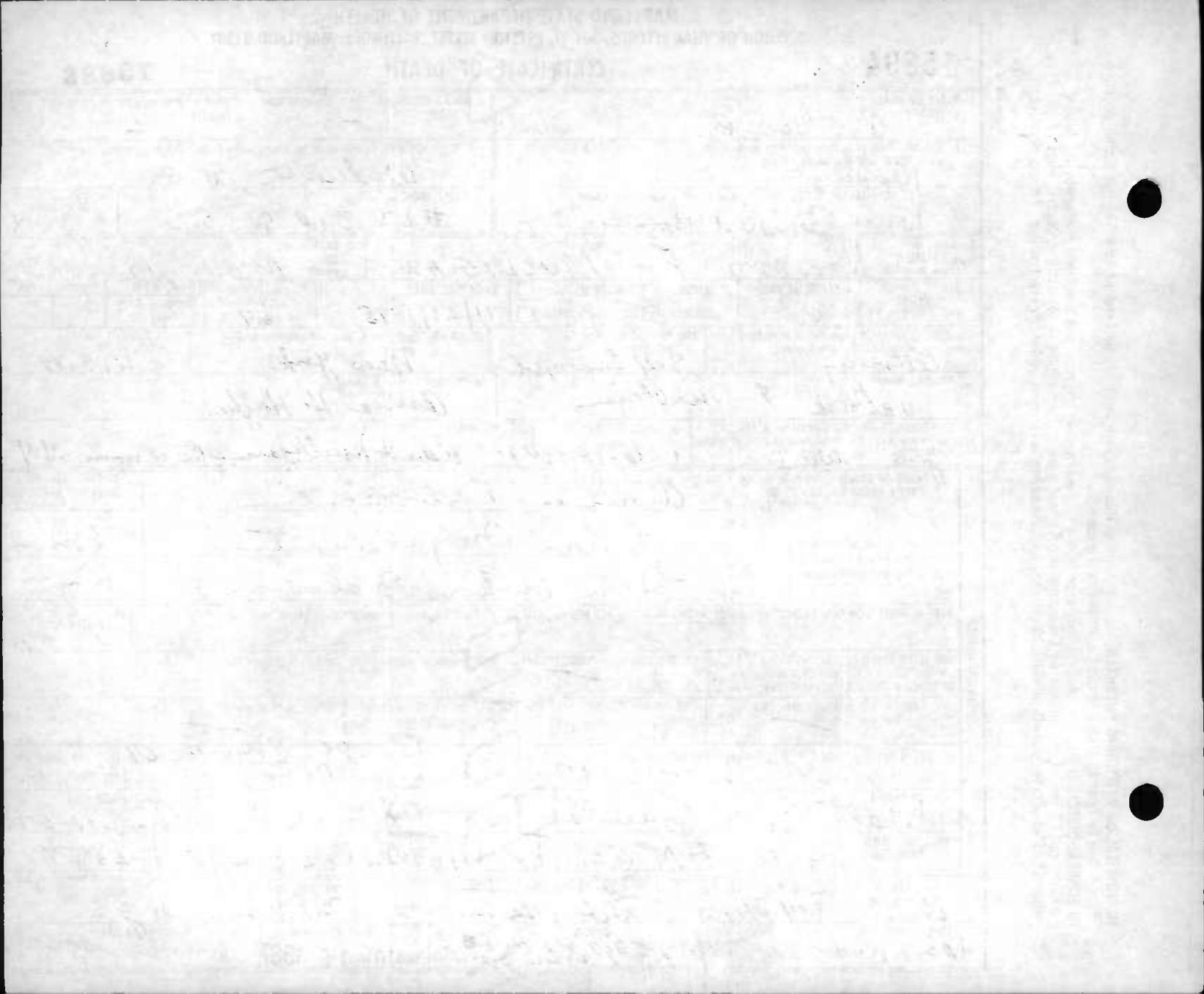
**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <i>Pv. Geo. Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE — b. COUNTY —				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b 90		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i> 47-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kensington Rest Home</i>				d. STREET ADDRESS <i>#22 3rd. St. S.E.</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>Howard F. Mulligan</b>		First	Middle	Lost	4. DATE OF DEATH	Month	Doy	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>11/29/1898</i>	9. AGE (In years last birthday) <i>69 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attorney</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
13. FATHER'S NAME <i>Patrick E. Mulligan</i>			14. MOTHER'S MAIDEN NAME <i>Anna H. Hagan</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes WWI</i>			16. SOCIAL SECURITY NO. <i>126-18-5642</i>	17. INFORMANT <i>Robert Mulligan - Casenova N.Y.</i>	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4331</i> DUE TO <i>Auricular Fibrillation</i> INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>								
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO <i>6 hr. Myocarditis</i> 6 mos (c) DUE TO <i>Gen. Atherosclerosis</i> 3 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour: o.m. — p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —		
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 11 1967</i> to <i>Nov 11 1967</i> , that (I) (we) last saw the deceased alive on <i>Nov 11 1967</i> and that death occurred at <i>10P.M.</i> from causes and on the date stated above.								
22a. SIGNATURE <i>Walter E. McNamee</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Nov 11-67</i>				
22c. PHYSICIAN'S NAME (Type) <i>WALTER E. McNAMEE</i>		22d. ADDRESS <i>701 No Canal St. WASH DC</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/14/1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Peter's Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Mt. Vernon, N.Y.</i>		
24. FUNERAL DIRECTOR <i>JAS. T. RYAN, INC. of Washington D.C.</i>		ADDRESS <i>317 Park Ave. S.</i>		25a. REC'D BY REGISTRAR <i>YES</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Ryan</i>		
VR A15 (4) 25M 1/67		317 Park Ave. S.		DATE <i>NOV 15 1967</i>				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15895		15887	
1. PLACE OF DEATH a. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hosp.		d. STREET ADDRESS 308 Gorman Ave.	
3. NAME OF DECEASED (Type or print) Benjamin T. Murphy		4. DATE OF DEATH Month 11 Year 1967	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/96 9. AGE (In years lost birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) engineer		10b. KIND OF BUSINESS OR INDUSTRY US Govt	
11. BIRTHPLACE (County & State, or foreign country) Scaggsville, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Murphy		14. MOTHER'S MAIDEN NAME Marion Gates	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-09-2904 Mrs. B. T. Murphy - Ahane Address	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 157X DUE TO CARCINOMATOSIS INTERVAL BETWEEN ONSET AND DEATH 1 MONTH	
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO CARCINOMA OF PANCREAS 6 MONTHS (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 20d. INJURY OCCURRED p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-1, 1967, to 11-11, 1967, that (I) (we) last saw the deceased alive on 11-10, 1967, and that death occurred at 12:30 AM, from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 11-11-67	
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) C. J. Houmann		22d. ADDRESS RIVERDALE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11-13-67		23b. DATE THEREOF St Paul's Lutheran Fulton Md.	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Bevitt Donaldson Laurel, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE			
DATE NOV 16 1967			

1982

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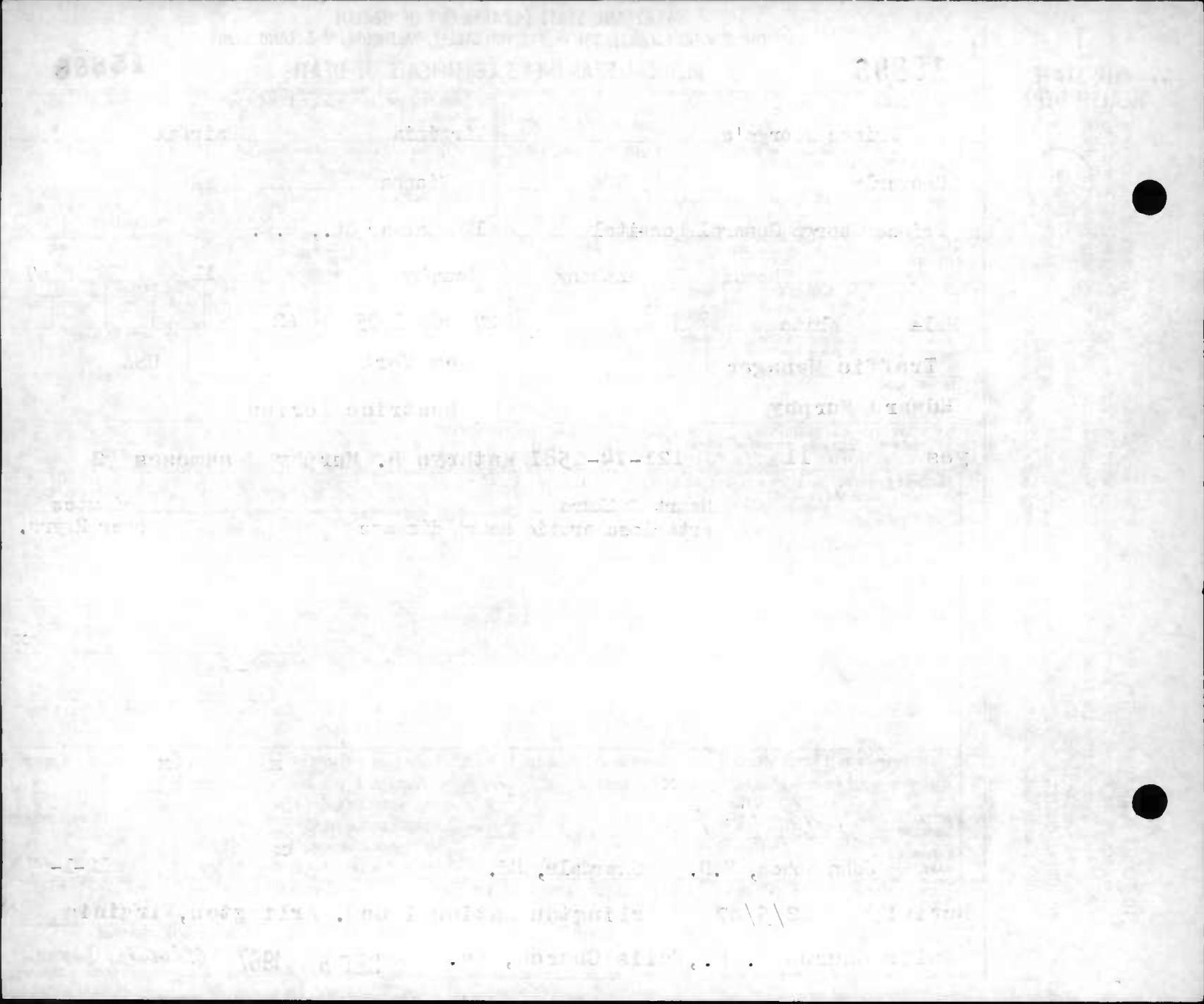
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm file 5, may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15895		15888	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>	
d. STREET ADDRESS <b>120 Casmar St., S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas Anthony Murphy</b>		4. DATE OF DEATH Month <b>11</b> Day <b>30</b> Year <b>1967</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 July 1925</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Traffic Manager</b>		9. AGE (In years lost birthday) <b>42 yrs.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>Edward Murphy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b> <b>WW II</b>		16. SOCIAL SECURITY NO. <b>121-14-1581</b>	
17. INFORMANT <b>Kathryn B. Murphy</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> Y200 DUE TO <b>Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ minutes DUE TO (c) _____ over 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/67</b>	23c. NAME OF CEMETERY OR CREMATORIALy <b>Arlington National Cem.</b>
23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>		23e. REC'D BY REGISTRAR ADDRESS	
24. FUNERAL DIRECTOR <b>Falls Church F. H., Falls Church, Va.</b>		25b. REGISTRAR'S SIGNATURE DATE <b>DEC 5 1967</b> <i>Charles J. ...</i>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. **Doges** **one** **2**  
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)  
25M 1/67

## **CERTIFICATE OF DEATH**

15889

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Washington, D. C.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 16 <b>2mos., 2 wks.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>		d. STREET ADDRESS <b>No fixed address</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>William J. P. Murphy</b>		First	Middle	Last	4. DATE OF DEATH <b>11 20 1967</b>	Month	Day	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/3/1912</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Patrick Murphy</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Cahalin</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>060-07-9980</b>		17. INFORMANT <b>Decedent</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: <b>Bronchogenic carcinoma, left</b>								
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>pulmonary tuberculosis, far advanced</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>11/20/1967</b>		(County) <b>11/20/1967</b> (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/6/1967</b> to <b>11/20/1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11/20/1967</b> , and that death occurred at <b>1:10A M</b> , from causes and on the date stated above								
22a. SIGNATURE <b>Moe Weiss</b>								
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>						
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-22-67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National</b>		23d. LOCATION (City or Town) (County) <b>Arlington</b> (State) <b>Va.</b>		
24. FUNERAL DIRECTOR <b>F. J. COLLINS 3826-14th St. N.W.</b>		ADDRESS <b>D.C.</b>		25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15893

CERTIFICATE OF DEATH

15890

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	c. LENGTH OF STAY IN 1b <b>21 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	d. STREET ADDRESS <b>6403-45th Place</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eugene Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Ninnie</b>	Middle <b>E.</b>	Last <b>Neel</b>
4. DATE OF DEATH <b>11 25 1967</b>	Month Year	Day	Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-2-76</b>
9. AGE (In years last birthday) <b>91 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>JOSEPH CLAYTON BOGLE</b>		
14. MOTHER'S MAIDEN NAME <b>MARTHA BOGLE</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.	17. INFORMANT <b>HARRIET BEAM, DAU. SAME AS #2</b>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ACUTE PNEUMONITIS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-4</b> , 1967, to <b>11-25</b> , 1967, that (I) (we) last saw the deceased alive on <b>11-25</b> 1967, and that death occurred at <b>9:05 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>C. J. Houmann</b>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>C. J. Houmann</b>	22d. ADDRESS <b>RIVERDALE MD.</b>	22b. DATE SIGNED <b>11-26-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/29/67</b>	23c. NAME OF CEMETERY <b>Red Oak Cemetery</b>	23d. LOCATION (City or Town) <b>Ceres Bluff Virginia</b>
24. FUNERAL DIRECTOR <b>Gasch's</b>	ADDRESS <b>Hyattsville, Maryland</b>	25a. REC'D BY REGISTRAR <b>DEC 1 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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15899		15891												
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>					b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>14 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>4903 Edmonston Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>														
3. NAME OF DECEASED (Type or print) <b>William P. Nowell</b>		First <b>William</b>	Middle <b>P.</b>	Lost <b>Nowell</b>	4. DATE OF DEATH <b>Nov. 17 1967</b>		Month <b>Nov.</b>	Doy <b>17</b>	Year <b>1967</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. BIRTH DATE <b>1/14/08</b>		9. AGE (In years at birthday) <b>59</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>C.I.A.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Anne Arundel Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William G. Nowell</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. Hartge</b>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577 10 7666</b>		17. INFORMANT <b>Alice M. Nowell Same as #2 (wife)</b>		Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe coronary arteriosclerosis with Left ventricular infarct</b> DUE TO <b>Generalized peritonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Chronic pyelonephritis</b> DUE TO <b>Atelectasis of Right Lower Lobe</b>												INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Laurel</b>		(County) <b>P.G.</b>		(State)				
21. I certify that (I) (this hospital) attended the deceased from <b>3 Nov 1967</b> to <b>November 17 1967</b> , that (I) (we) last saw the deceased alive on <b>17 Nov 1967</b> , and that death occurred at <b>10:55 AM</b> from causes and on the date stated above.														
22a. SIGNATURE 		22b. DATE SIGNED <b>11/18/67</b>												
22c. PHYSICIAN'S NAME (Type) <b>Robert Deitz</b>		22d. ADDRESS <b>Prince George Plaza Hyattsville, Md.</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/21/67</b>		23c. NAME OF CEMETERY OR CEMATORIUM <b>St. Mary's</b>		23d. LOCATION (City or Town) <b>Laurel</b>		(County) <b>P.G.</b>		(State)				
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D. BY REGISTRAR <b>NOV 22 1967</b>		25b. REGISTRAR'S SIGNATURE 								

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

15800		15892	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>P.G.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> XXXXXXXXXXXXXXXXXXXXXXX	
c. LENGTH OF STAY IN lb <u>7-18-67</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DIST. Hg's</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent H. Home</u>		d. STREET ADDRESS <u>7602 Elmhurst Street</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Edna MAY</u>		First <u>Edna</u> Middle <u>MAY</u> Last <u>OWENS</u>	<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>7</u> Year <u>1967</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1895</u> 9. AGE (In years last birthday) <u>72 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.w.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>XXXXXX MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE W. BARNES</u>		14. MOTHER'S MAIDEN NAME <u>EVA MILLARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>J. THEODORE OWENS</u>	
17. INFORMANT <u>J. THEODORE OWENS</u>		Address <u>Sane on # 2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lympho SARCOMA</u> DUE TO <u>2001</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. MEDICAL CERTIFICATION</b> ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>20d. INJURY OCCURRED While at work</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>20f. (City or town) (County) (State)</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 1965</u> to <u>Nov. 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov. 6 1967</u> , and that death occurred at <u>2:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>WB Sheer</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Nov. 7, 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER</u>		22d. ADDRESS <u>6400 Marlboro Pike SE Wash. DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/10/67</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>CEDAR HILL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, PRINCE GEORGES, Md.</u>	
24. FUNERAL DIRECTOR <u>Ronald E. Welbeling</u>		ADDRESS <u>4308 Scrutton Rd</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> <u>Scuttles Rd</u> <u>Scuttles Md</u> <u>DATE NOV 10 1967</u>	

2287

THREE TO ONE HUNDRED

BUCKED DOWN

ONE HUNDRED EIGHTY FIVE

DECEMBER FIFTEEN

10-21-1

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BUCKED DOWN

ONE HUNDRED EIGHTY FIVE

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

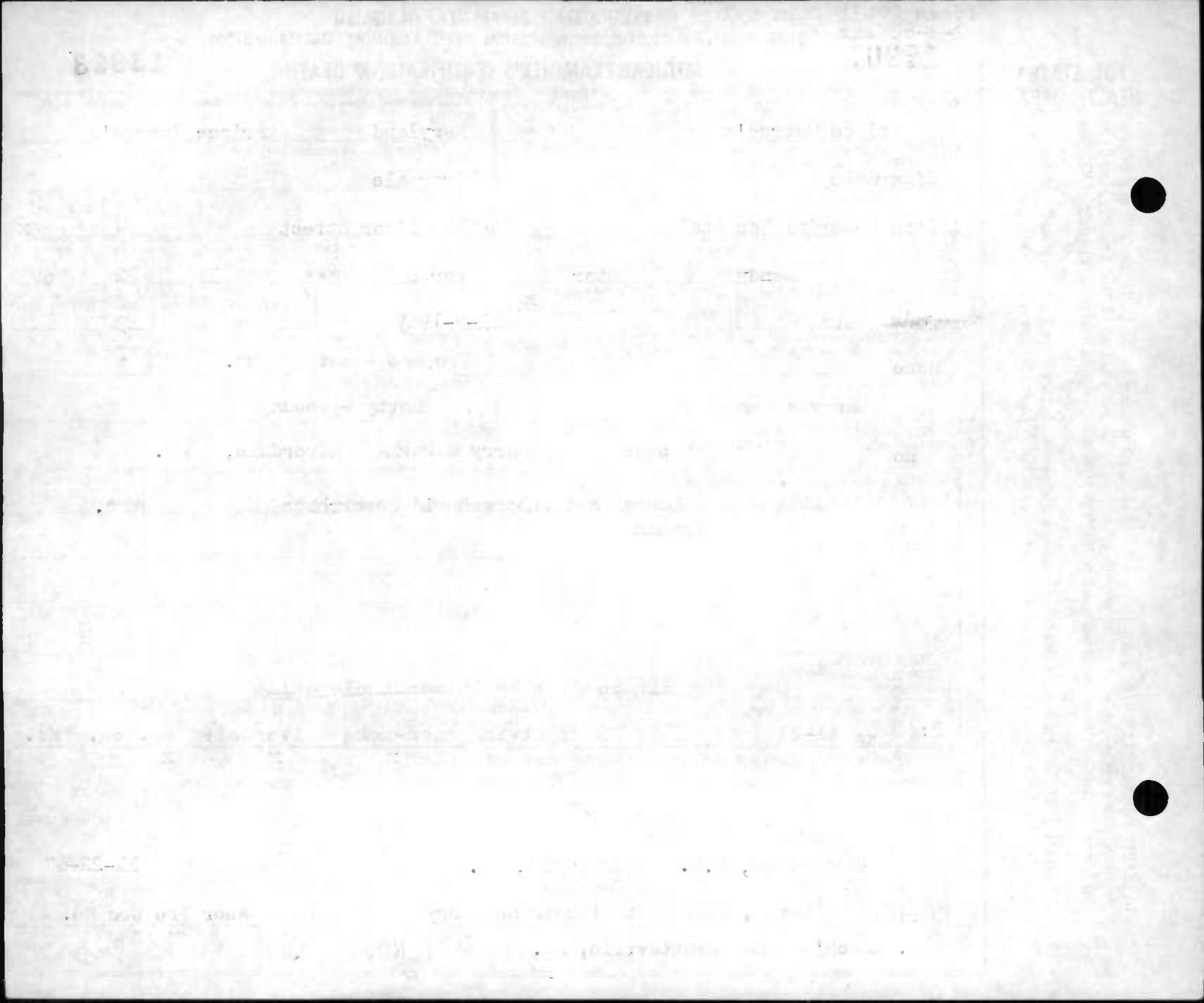
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 20&21 Film 397 MARYLAND STATE DEPARTMENT OF HEALTH  
2-2-68 amz DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
15901

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15893

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>DOA</b>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
d. STREET ADDRESS <b>4712 Oliver Street</b>		16-1											
3. NAME OF DECEASED (Type or print) <b>Wendy</b>		First <b>Star</b>	Middle <b>Parks</b>	Last <b>11</b>	4. DATE OF DEATH <b>22</b>	Month <b>11</b>	Day <b>19</b>	Year <b>67</b>					
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-9-1967</b>	9. AGE (In years last birthday) <b>— yrs.</b>	IF UNDER 1 YEAR Months <b>13</b>	IF UNDER 24 HRS. Days <b>13</b>	Hours <b>13</b>	Min. <b>13</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pro Geo County Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Pro Geo County Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>								
13. FATHER'S NAME <b>Harry W Parks Sr</b>		14. MOTHER'S MAIDEN NAME <b>Betty L Woods</b>		Address									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Harry W Parks Riverdale, Md.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural and subarachnoid hemorrhage</b> DUE TO <b>Trauma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>8:00 am 11-21 1967</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Hit on face by 16 month old child</b>		20c. TIME OF INJURY Month, Day, Year <b>8:00 am 11-21 1967</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> <b>at work</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Living room-home</b>	20f. (City or town) <b>Riverdale</b>	(County) <b>Pr.Geo.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John Kehoe</i>		EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <b>11-22-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 24, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) <b>Colmar Manor Pro Geo Md.</b>			25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>		ADDRESS											



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
15902 CERTIFICATE OF DEATH 15894														
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
Prince Georges MARYLAND			a. STATE Virginia b. COUNTY Fairfax ✓											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greenbelt Convalescent Center			d. STREET ADDRESS 10013 Clearfield Ave.											
3. NAME OF DECEASED (Type or print) ELIZABETH			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX Female			6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1900	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (County & State, or foreign country) Mt. Holly, New Jersey	12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Harry G. Duvall			14. MOTHER'S MAIDEN NAME Margaret Rogers											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 578-09-9554D			17. INFORMANT Mrs. James M. Miller			Address 10013 Claerfield Vienna, Virginia					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X			Coxsackie Decompenstion 2 day											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)			Bronchitis pneumonia 4 day											
} (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 11-19-67 to 11-25-67, that (I) (we) last saw the deceased alive on 11-24-67, and that death occurred at 3:00 P.M. from the causes end on the date stated above.														
22a. SIGNATURE Wm. C. Weintraub			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED								
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS Greenbelt, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/27/67			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill			23d. LOCATION (City, town or county) Suitland (State) Maryland					
24 FUNERAL DIRECTOR'S SIGNATURE <i>Wm. C. Weintraub</i>			ADDRESS Money & King Vienna Funeral Home Vienna, Va.			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>					
VR A15 (4) 20M 5-63						DATE NOV 28 1967								

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Wormwood

5-25-11

5-25-11

Wormwood

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15903

## CERTIFICATE OF DEATH

15895

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN lb <b>11 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	d. STREET ADDRESS <b>4303 29th Street</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louis Earl Payne</b>	First <b>Louis</b>	Middle <b>Earl</b>	Last <b>Payne</b>
4. DATE OF DEATH <b>November 21 1967</b>	Month <b>November</b>	Doy <b>21</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/5/1893</b>
9. AGE (In years lost birthday) <b>74 yrs.</b>	10. KIND OF BUSINESS OR INDUSTRY <b>C. &amp; P. Tele. Co.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Payne</b>	14. MOTHER'S MAIDEN NAME <b>Roberta Haynes</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>577-01-2066A</b>	17. INFORMANT <b>Mrs. Hazel A. Payne (above address)</b>	Address <b>(Wife)</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma to the liver and brain.</b>			INTERVAL BETWEEN ONSET AND DEATH
1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Bronchogenic Carcinoma, right upper lobe</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>1960</b> to <b>NOV</b> , 1967, that (1) (we) last saw the deceased alive on <b>NOV 20 1967</b> and that death occurred at <b>7:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Benjamin S. Miller</b>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. A. M. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11/21/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. Benjamin S. Miller</b>	22d. ADDRESS <b>3824 34th St., Mt. Rainier, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/24/67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft. Lincoln Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>	ADDRESS <b>Mt. Rainier, Maryland</b>	25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G395 12/15/67 ph

**CERTIFICATE OF DEATH**

15904		15906	
1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Pr. George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HYATTSVILLE, MD.</i>		c. LENGTH OF STAY IN lb <i>2 months</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>CARROLL MANOR</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ALICE</i>		First <i>HELENA</i>	Middle <i>Peachick</i>
4. DATE OF DEATH Month <i>11</i>		Month <i>21</i>	Day Year <i>1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-23-1878</i>
9. AGE (In years Last birthday) <i>88</i> yrs.		10. BIRTHPLACE (County & State, or foreign country) <i>ILLINOIS</i>	11. CITIZEN OF WHAT COUNTRY? <i>USA</i>
12. FATHER'S NAME <i>HOMER SWEETY</i>		13. MOTHER'S MAIDEN NAME <i>ANNA MARIE HOLLINGSHEAD</i>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes give war or dates of service) <i>332X</i>		15. SOCIAL SECURITY NO. <i>490-24-0247</i>	16. INFORMANT <i>Sister M. Dolores, Carroll Manor</i>
17. INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Cerebral Vasc. Thrombosis</i> DUE TO (c) <i>Gen. Arteriosclerosis (Cerebral)</i> DUE TO	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>July 1958</i> , to <i>Nov 1967</i> , that (I) (we) last saw the deceased alive on <i>Nov 20 1967</i> , and that death occurred at <i>6:20 A.M.</i> from causes and on the date stated above.		22b. DATE SIGNED <i>11/21/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>James J. Foster</i>		22d. ADDRESS <i>1746 K St N.W.</i>	22e. ATTENDING MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 24, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>HIGHLAND LAWN CEM.</i>
24. FUNERAL DIRECTOR <i>Hanlon Funeral Home</i>		25a. ADDRESS <i>21149 Wisc. Ave. N.W. D.C.</i>	25b. LOCATION (City or Town) (County) (State) <i>TERRE HAUTE INDIANA</i>
		25c. REC'D BY REGISTRAR <i>NOV 30 1967</i>	25d. REGISTRAR'S SIGNATURE <i>James J. Foster</i>

2010年1月1日，中国科学院植物研究所植物园内，中科院植物所研究员王康乐在整理标本。王康乐是植物分类学家，长期从事被子植物分类学研究，尤其对双子叶植物的分类学研究有深入的了解。



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

1  
15905

**CERTIFICATE OF DEATH**

15897

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston		c. LENGTH OF STAY IN lb		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4802 51st Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Clarence Middle F. Lost Powell		4. DATE OF DEATH Nov. 12, 1967 Month Doy Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 64 (In years lost birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal worker		10b. KIND OF BUSINESS OR INDUSTRY construction		
13. FATHER'S NAME Edward Powell		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		12. CITIZEN OF WHAT COUNTRY? USA		
16. SOCIAL SECURITY NO. 216 07 6658		17. INFORMANT Mrs. Maude L. Powell Same as #2 (wife) Address		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Congestive Heart Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>27 hrs</i> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Dis.</i> DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 1</i> , 1967, to <i>Nov 12</i> , 1967, that (I) (we) last saw the deceased alive on <i>Nov 11</i> 1967, and that death occurred at <i>20241 M</i> , from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
22a. SIGNATURE <i>Ermo P. Ingel</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>Nov 12 1967</i>	
22c. PHYSICIAN'S NAME (Type) Ermo P. Ingel, M.D.		22d. ADDRESS Washington D. C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 15, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge

11622

REVIEW OF THE LITERATURE ON THE INFLUENCE OF

THE CULTURE OF SOYBEANS ON THE ENVIRONMENT

AND THE USE OF SOYBEAN RESIDUES AS AN ALTERNATIVE SOURCE OF ENERGY

IN BRAZIL

JOSE A. S. SOARES

DEPARTAMENTO DE AGROPECUÁRIA  
UNIVERSIDADE FEDERACAO  
CAMPUS DA SERRA DA MANTIQUEIRA  
SANTOS - SP - 14285-000

BRASIL

1995

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WWW: <http://www.agro.pucsp.br/~soares/>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**1**  
 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical examiner Dr John Kehoe notified and approved on Nov 13, 1967.

15906		15898	
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>15 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kentland</b> d. STREET ADDRESS <b>7506 Forest Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First</b> <b>Oliver</b> <b>Middle</b>		4. DATE OF DEATH <b>Price</b> <b>Nov. 13 1967</b>	
5. SEX <b>Male</b> 6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		8. DATE OF BIRTH <b>7-27-32</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>D C Government</b>		9. AGE (In years lost birthday) <b>35 yrs.</b>	
10c. FATHER'S NAME <b>Claude O Price</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>577 42 3691</b>	
17. INFORMANT <b>Doris J Price</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO <b>5810</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Massive upper G.I. bleeding</b> DUE TO <b>last.</b> (c) <b>Hepatic cirrhosis -</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>p.m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>1113</b> (County) <b>11-13</b> (State) <b>1967</b>	
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <b>11-13 1967</b> , to <b>11-13 1967</b> , that (II) <input type="checkbox"/> last saw the deceased alive on <b>11-13 1967</b> , and that death occurred <b>at 10 P.M.</b> from causes and on the date stated above.		22b. DATE SIGNED <b>11-14-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Max M. Herzberg, M.D.</b>		22d. ADDRESS <b>3308 Dodge Park Rd. Landover, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 17, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 17 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>John L. Judge</b>	

86667

11/20/76 10:10 AM

100% full

front

empty back

highline

100%

empty

100% full

Indoor laundry receptacle

no

no

100% full

empty

empty

empty

empty

empty

100% full

empty

no, and by no, I mean like this

empty

no

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

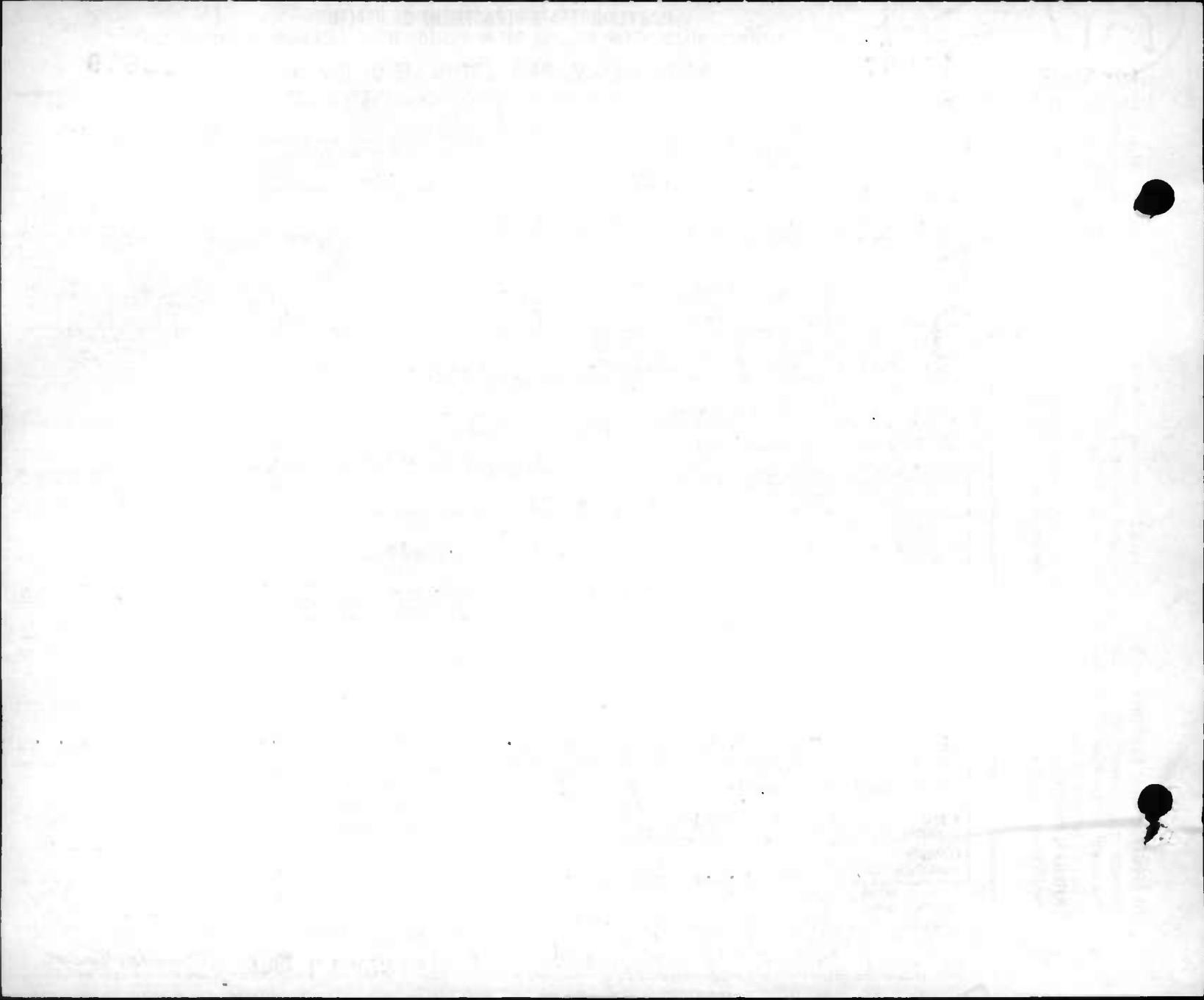
15899

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

15907		1		MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
o. COUNTY Prince George's		o. STATE Maryland											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 17 days		b. COUNTY Prince George's									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 02-2											
3. NAME OF DECEASED (Type or print) Ida		First	Middle	Lost	4. DATE OF DEATH 11	Month	Doy	Year					
S. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	<input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-20-40	9. AGE (In years lost birthday) 26 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital worker		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Shadyside Md.			12. CITIZEN OF WHAT COUNTRY? US 19						
13. FATHER'S NAME Frederick E Proctor		14. MOTHER'S MAIDEN NAME Lucy Estep				Address Lucy E Proctor Shadyside Md.							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH 24 hours							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Peripheral Venous thrombosis DUE TO (c) Immobilization for treatment of multiple fractures, 17 days													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH: driver of car involved in collision		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. 7:30am p.m. 10-20 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rte. 202 & Town Farm Rd., Upper Marlboro, P.G. Md		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John Kehoe</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 11-6-67							
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 8 1967		23c. NAME OF CEMETERY OR CREMATORIUM Woodlief		23d. LOCATION (City or Town) Bry besville Rd		(County) (State)					
24. FUNERAL DIRECTOR Bernard Hardaway Galveston Ltd		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE NOV 13 1967		DATE NOV 13 1967					



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15908

CERTIFICATE OF DEATH

15900

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BLADENSBURG</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BLADENSBURG</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5018-57th AVE. APT. A-1</b>			d. STREET ADDRESS <b>5018-57th Ave.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>ELIZABETH</b>	Middle <b>F.</b>	Last <b>PULLIN</b>	4. DATE OF DEATH	Month Nov 8, Day Year <b>1967</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug 26, 1876</b>	9. AGE (In years lost birthday) yrs. <b>91</b>	IF UNDER 1 YEAR Months Days Hours Min. 00 00 00 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>	
13. FATHER'S NAME <b>John E. Sipe</b>			14. MOTHER'S MAIDEN NAME <b>Mary A. Hull</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Pauline Campbell</b> day same as #2 Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Heart Disease</b> INTERVAL BETWEEN 443X DUE TO <b>3 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO <b>15 yrs.</b> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Colmar Manor</b>	(County) <b>P.G.</b> (State) <b>Md.</b>
21. I certify that (I) (This hospital) attended the deceased from <b>March 3, 1957</b> , to <b>Nov. 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 7, 1967</b> , and that death occurred at <b>11 P.M.</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Charles C. Hageage</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 9, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles C. Hageage</b>		22d. ADDRESS <b>3308 Perry St. Mt. Rainier, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/11/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

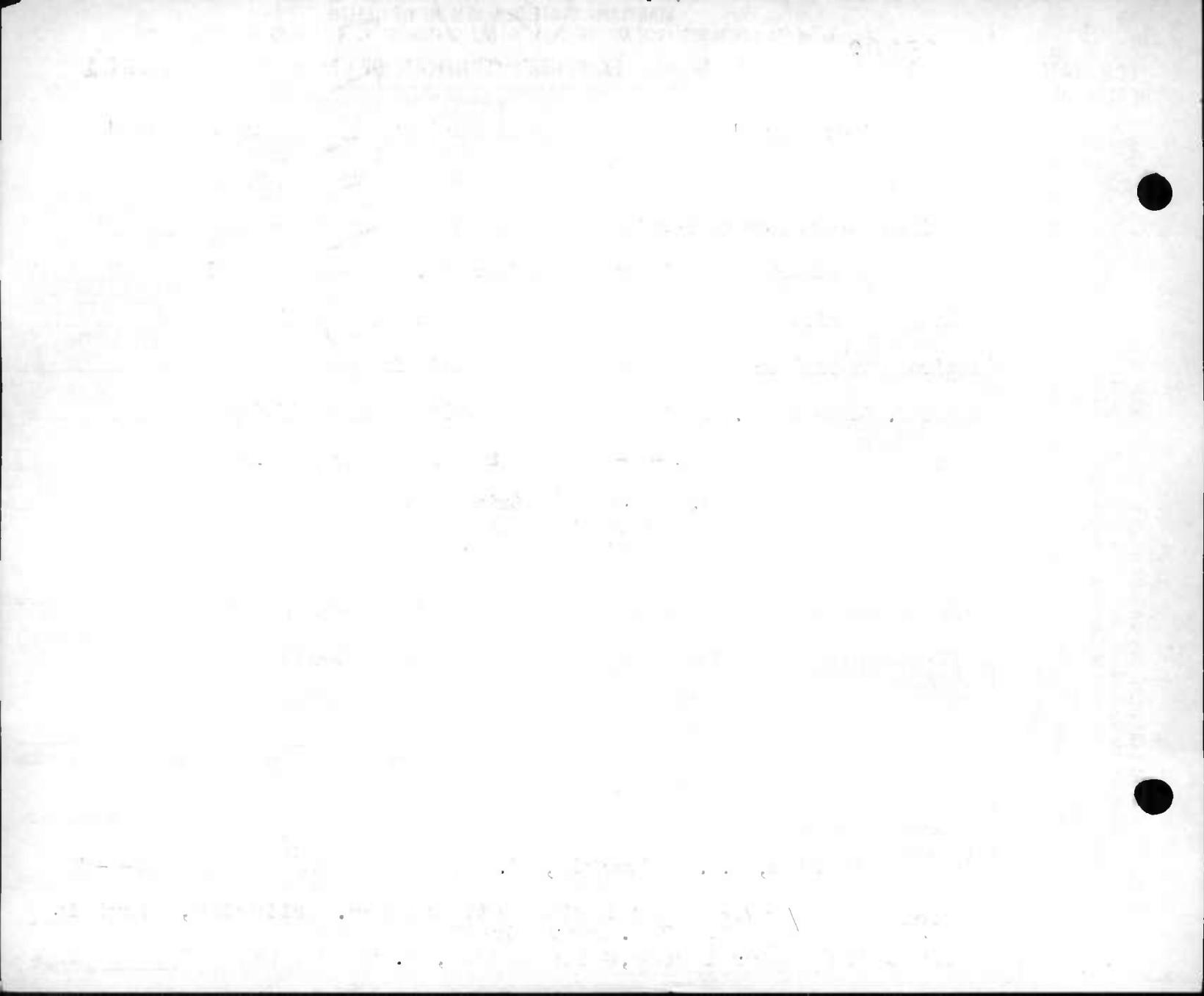
15901

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert</b>		First <b>Wilton</b>	Middle <b>Renfroe (JR.)</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 June 1934</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Active Duty Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	9. AGE (In years lost birthday) <b>33 yrs.</b>
13. FATHER'S NAME <b>Robert W. Renfroe (SR.) living</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>524-36-2012</b>	17. INFORMANT Address <b>Ruby Gale (Bowers) Renfroe</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric contents</b> DUE TO <b>And metastatic carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>151X</b> (b) <b>From carcinoma of stomach</b> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. ACTUAL SIGNATURE <i>John Kehoe</i>		22. DATE SIGNED 11-9-67	
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>		23. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cem. Arlington, Virginia</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/13/67</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <i>Charles J. Jones</i>		23c. NAME OF CEMETERY OR CREMATORY <b>1102 W Broad Street</b>	25a. REC'D BY REGISTRAR <b>Charles J. Jones</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>
		Date <b>NOV 13 1967</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

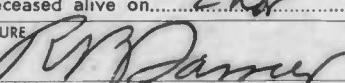
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15902

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		b. COUNTY <b>Pr. Gee's</b>	
c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 113 (Main Street)</b>		d. STREET ADDRESS <b>Box 113 (Main Street)</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Edward Ridgely</b>		First <b>Charles</b>	Middle <b>Edward</b>
4. DATE OF DEATH <b>November 3, 1967</b>	Month <b>November</b>	Day <b>3</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1889</b>
		WIDOWED <input type="checkbox"/>	9. AGE (in years last birthday) <b>78 yrs.</b>
		DIVORCED <input type="checkbox"/>	10. IF UNDER 1 YEAR Months <b>0</b>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rot'd Carpenter</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Edward Ridgely</b>		14. MOTHER'S MAIDEN NAME <b>Marian Marie Sweeney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>220-09-6257</b>	
17. INFORMANT <b>Mrs. Marie M. Ridgely-Same as Item 16.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)  332X		Cerebral Thrombosis	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)  (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 1966 to Nov. 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>2 Nov. 1967</b> , and that death occurred at <b>4:15 A.M.</b> from the causes and on the date stated above.			
22e. SIGNATURE 		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>
		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert B. Sasscer, M.D.</b>		22d. ADDRESS <b>Upper Marlboro, Maryland 20870</b>	

23e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/6/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mt. Carmel Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Upper Marlboro, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE 	25. REC'D BY REGISTRAR <b>NOV 14 1967</b>	25d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

15911		15903	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> 4 days c. LENGTH OF STAY IN lb		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg</b> d. STREET ADDRESS <b>2120 Upsher Street</b>	
<b>3. NAME OF DECEASED</b> First <b>Edward</b> Middle <b>E.</b> Last <b>Riles</b> (Type or print)		<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>4,</b> Year <b>1967</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>3/15/94</b>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gravedigger</i>	9. AGE (In years last birthday) yrs. <b>73</b>
13. FATHER'S NAME <i>Charles Riles</i>		11. BIRTHPLACE (County & State, or foreign country) <b>Md</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WWI</b>	17. INFORMANT <i>William Chase 4110 Balt. Ave Bladensburg</i>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung &amp; Pneumonitis</i> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Metastasis to Liver</i> DUE TO (c)			
<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Baltimore</b> (County) <b>Md</b> (State) <b>Md</b>			
21. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>Oct. 31, 1967</b> , to <b>Nov. 4, 1967</b> , that <b>(H)</b> (we) last saw the deceased alive on <b>Nov. 4, 1967</b> , and that death occurred at <b>11 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Edwin J. Jensen</i>		M.O. <b>ATTENDING PHYS.</b> <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>11/7/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Edwin J. Jensen, M. D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11-9-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore Nat.</b>	23d. LOCATION (City or Town) <b>Catonsville</b> (County) <b>Md</b> (State) <b>Md</b>
24. FUNERAL DIRECTOR <b>N.S. WASHINGTON &amp; SONS INC.</b>		ADDRESS <b>4925 DEANNE KIVE, N.E. WASH., D.C.</b>	25a. RECD. BY REGISTRAR DATE <b>NOV 13 1967</b>
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15904

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>9 days</b>		b. COUNTY <b>Prince Georges</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>		
d. STREET ADDRESS <b>7008 F. Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>Charles</b>	Middle <b>Amos</b>	Last <b>Rogers Sr.</b>	4. DATE OF DEATH Month <b>Nov.</b> Day <b>8,</b> Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>8/26/18</b>	9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Construction</b>		10b. KIND OF BUSINESS OR BUILDING <b>Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Layton Rogers</b>			14. MOTHER'S MAIDEN NAME <b>Bertha Lilly</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>225 24 4896</b>		17. INFORMANT Address <b>Marguerite K. Rogers Same as #2 (wife)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Margaret Hemmings</i> OUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) OUE TO last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>Oct. 30, 1967</b> , to <b>NOV. 8, 1967</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>Nov. 8, 1967</b> , and that death occurred at <b>1 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <i>Arnold G. Brody</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>9 Nov 67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M.D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/11/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) <b>Colmar Manor P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>			ADDRESS	25a. REC'D BY REGISTRAR DATE <b>NOV 14 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

4062

HARD 30-30MM RD

as test result

Brake

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simulating test

level C

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control

control

at time

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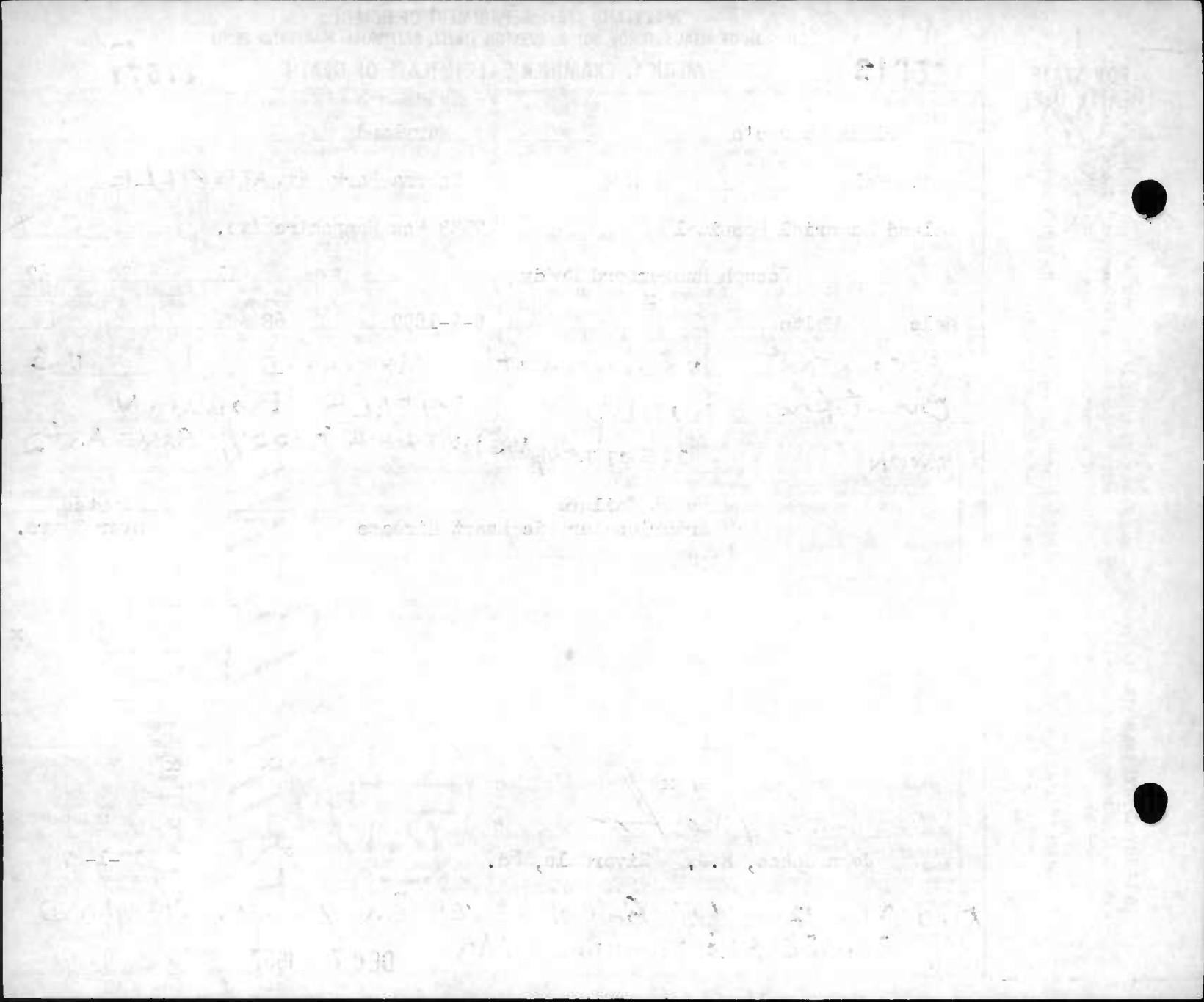
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
15913				17571			
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>PG GEO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park HYATTSVILLE</b> 16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>7333 New Hampshire Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Joseph Hungerford Ruddy</b>		First	Middle	Last	4. DATE OF DEATH	Month	Doy Year
S. SEX	6. COLOR OR RACE	7. MARRIED	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Male	White	WIDOWED	<input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-4-1899	68 yrs.	Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>ACCOUNTANT</b>		<b>U.S. GOVERNMENT</b>		<b>MARYLAND</b>		<b>U.S</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
<b>Christopher Ruddy</b>		<b>PHEKLA BOWMAN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
UNKNOWN		225 07 7544		<b>MRS P. VIRGINIA RUDDY, SAME AS #2</b>			
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <b>Heart failure</b>							
4200 DUE TO <b>Arteriosclerotic heart disease</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO							
last. (c)							
INTERVAL BETWEEN ONSET AND DEATH minutes							
over 3 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Kehoe</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b> Riverdale, Md. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22. DATE SIGNED <b>12-1-67</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)	
<b>BURIAL</b>		<b>12-4-1967</b>		<b>GATE OF HEAVEN CEM</b>		<b>WHEATON, MARYLAND</b>	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<b>A.W. CHAMBERS Co. RIVERDALE, MD</b>						<i>Charles Judge</i>	
DATE <b>DEC 7 1967</b>							



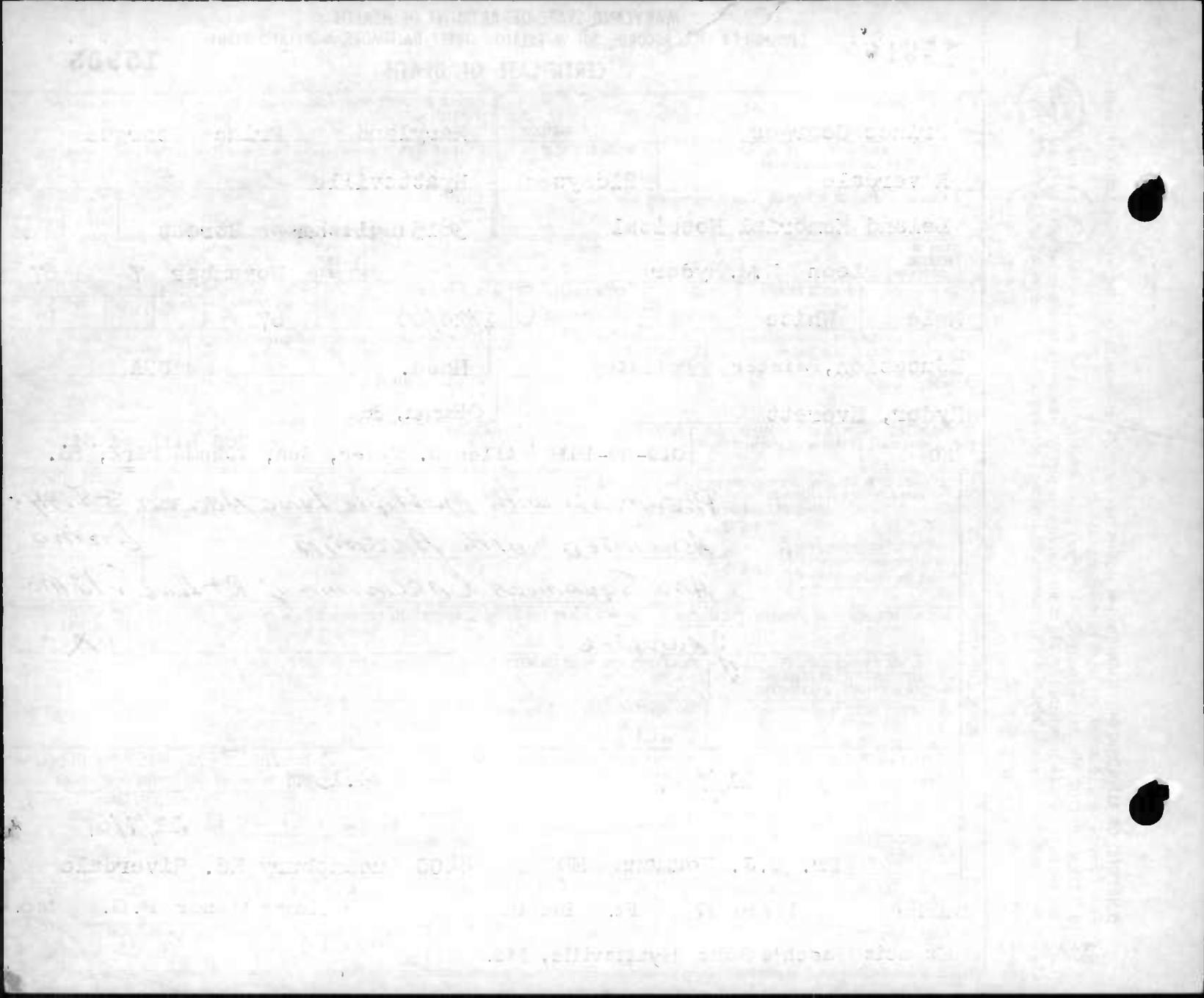
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15905

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>21 days</b>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>3815 Oglethorpe Street</b>		
73				16-1				
3. NAME OF DECEASED (Type or print) <b>Leon E.M. Ryder</b>		First	Middle	Lost	4. DATE OF DEATH <b>November 7 1967</b>	Month	Doy	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/24/00</b>	9. AGE (In years, lost birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Education, Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Ryder, Everett</b>		14. MOTHER'S MAIDEN NAME <b>Olsson, Ida</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>019-09-1618</b>		17. INFORMANT <b>Allen D. Ryder, Son, 706 Gilbert St., Takoma Park, Md.</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia with multiple lung abscesses</b>		DUE TO <b>493X</b>		INTERVAL BETWEEN <b>35 days</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) <b>Associated with Anemia</b>		DUE TO <b>6-12 mo</b>				
		(c) <b>And Squamous Carcinoma of Rt Lung</b>		DUE TO <b>? 18 mo</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>Jawrice</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Jawrice</b>						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>10-17 1967</b> , to <b>11-7 1967</b> , that (I) (we) last saw the deceased alive on <b>11-7-67 19</b> , and that death occurred at <b>4-15 pm</b> from causes and on the date stated above.								
22a. SIGNATURE <b>C.J. Houmann</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>11/7/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. C.J. Houmann MD</b>		22d. ADDRESS <b>4400 Queensbury Rd. Riverdale</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>		
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. RECEIVED BY REGISTRAR <b>Nov 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Juge</b>		
VR A15 (4) 25M 1/67				DATE				



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15915

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15906

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper [Pipes] and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>		d. STREET ADDRESS <b>35 A Ridge Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Joseph</b>		First	Middle	Last	4. DATE OF DEATH <b>November 18, 1967</b>	Month	Day Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11/22/02</b>	9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Joseph Carlyle Seward Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Almina Malliat</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Albert B. Seward</b>		909 California Ave. Pittsburgh, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> INTERVAL BETWEEN ONSET AND DEATH 1419 DUE TO <b>Metastatic Carcinoma</b> <b>1 year</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>P</b> last. DUE TO <b>Carcinoma of Tongue</b> <b>4 year</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1957</b> to <b>Nov. 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 18, 1967</b> , and that death occurred at <b>2:10 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>John C. Weintraub</b>				22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>11/18/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>William C. Weintraub, M. D.</b>		22d. ADDRESS <b>Greenbelt, Md.</b> Greenbelt Professional Bl'dg					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/21/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Louden Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore</b> Baltimore Md.	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b> Hyattsville, Md.				ADDRESS		25a. REC'D. BY REGISTRAR <b>NOV 22 1967</b>	25b. REGISTRAR'S SIGNATURE <b>James Judge</b>
VR A15 (4) 25M 1/67		DATE					

### Signons

Institute for Economic Research

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FOR STATE  
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

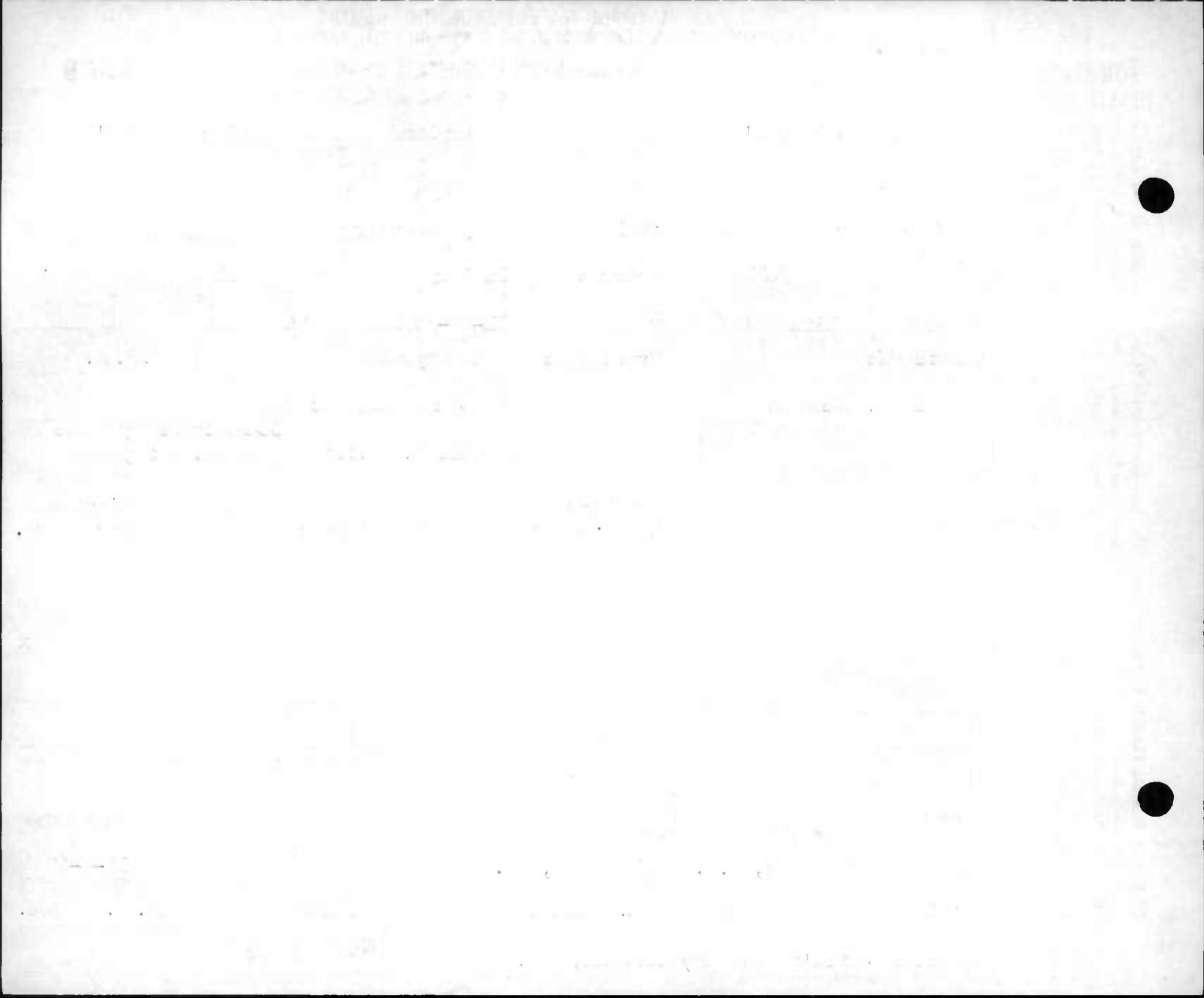
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15917

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15908

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Polly</b>	Middle <b>Gertrude</b>	4. DATE OF DEATH 11 8 19 67
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-27-1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9. AGE (In years lost birthday) <b>74 yrs.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Fred L. Denson</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Charline B. Gates</b>	
17. INFORMANT <b>7534 Newberry Lane</b>		18. MOTHER'S MAIDEN NAME <b>Lanham, Maryland</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> Conditions, if any, which gave rise to immediate cause (a) <b>443X</b> stating the underlying cause (b) <b>Hypertensive cardio vascular disease</b> lost. (c) <b>over 2 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>p.m.</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Lehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Riverdale, Md.</b>	
23a. BURIAL, CREMATION SPECIFY (Type) <b>Burial</b>		23b. DATE THEREOF <b>11/11/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft. Lincoln</b>
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D. BY REGISTRAR <b>NOV 14 1967</b>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

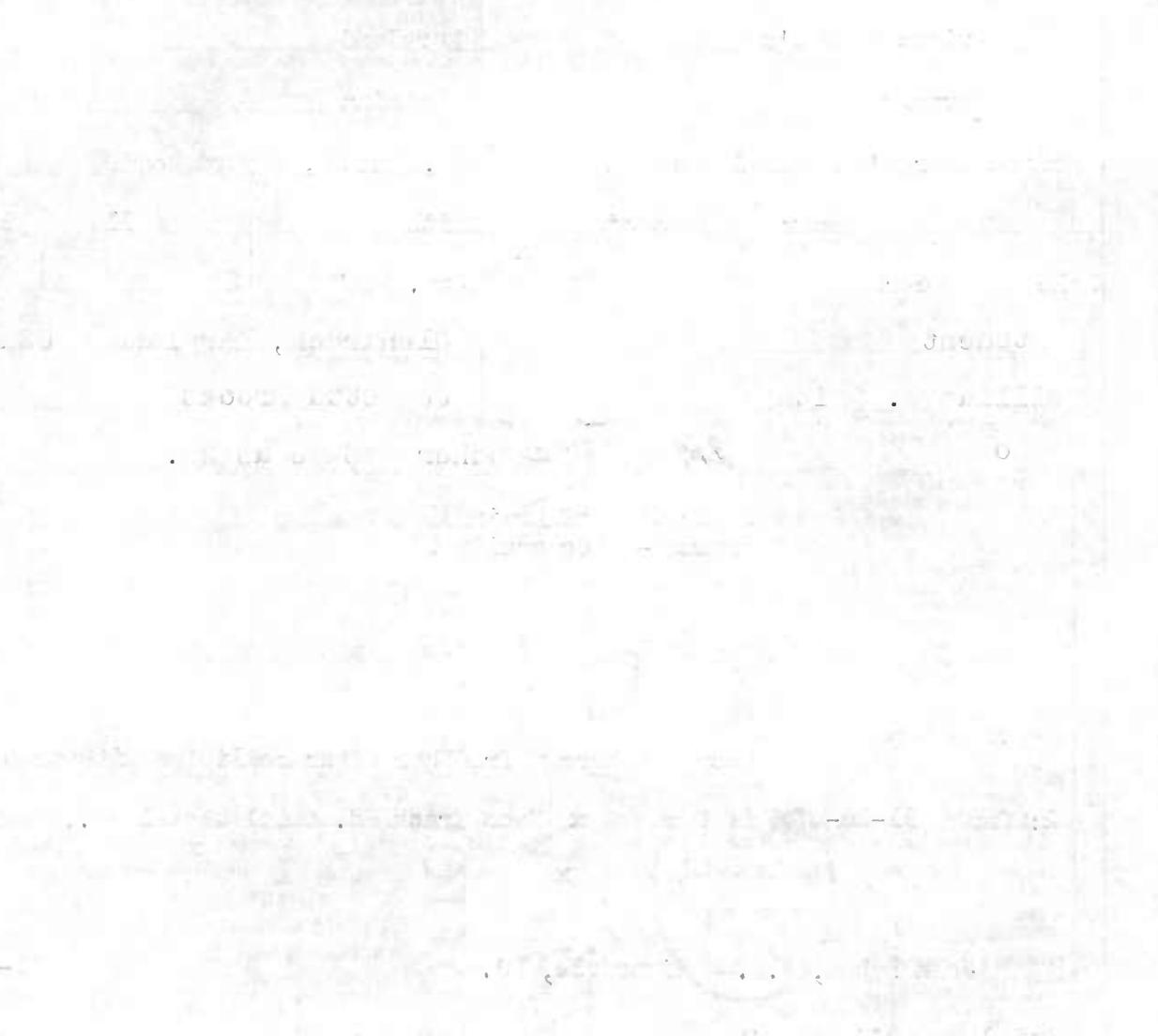
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15918		15969	
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lothian</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>Rt1, Box 40, Bayard Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Oscar Fremont Smith</b>		First	Middle
4. DATE OF DEATH	Month	Doy	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <b>9 Jan. 1947</b>	9. AGE (In years lost birthday) <b>20 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		11. BIRTHPLACE (State or foreign country) <b>Glenarden, Maryland</b>	
13. FATHER'S NAME <b>William W. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Jeanetta Brooks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>244-48-1192</b>	
17. INFORMANT <b>Mother</b>		Address <b>Same as 2d.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Iaceration of brain</b> 8234 DUE TO <b>Trauma - auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. MEDICAL CERTIFICATION PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant thrown from car after collision with tree.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>2:00 a.m. 11-16-1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Race Track Rd. &amp; Old Chapel Rd. Bowie, Md.</b>
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>John Kehoe, M.D. Riverdale, Md.</b>	
22. DATE SIGNED <b>11-17-67</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-20-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Adams Chapel Cemetery Lothian, Maryland</b>
23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>Rollins, Inc. 4339 Hunt Pl., N.E., DC</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15910

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>D. O. A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>5023 Geronimo Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <b>Robert</b>	Middle <b>Vincent</b>	Last <b>Smith</b>	4. DATE OF DEATH	Month <b>Nov.</b>	Doy <b>9,</b>	Year <b>1967</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>22 Jan 1916</b>	9. AGE (In years at birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Internal Revenue Service</b>				11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry J. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane McCarten</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. 17. INFORMANT <b>Robert K. Smith Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Liver failure</b> 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause lost. (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Kehoe</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>	Address (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/13/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Truman</b>	23d. LOCATION (City or Town) <b>Kendalltown</b>	(County) <b>Wisconsin</b>	(State)		
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Maryland</b>	ADDRESS		25a. REC'D BY REGISTRAR <b>NOV 13 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

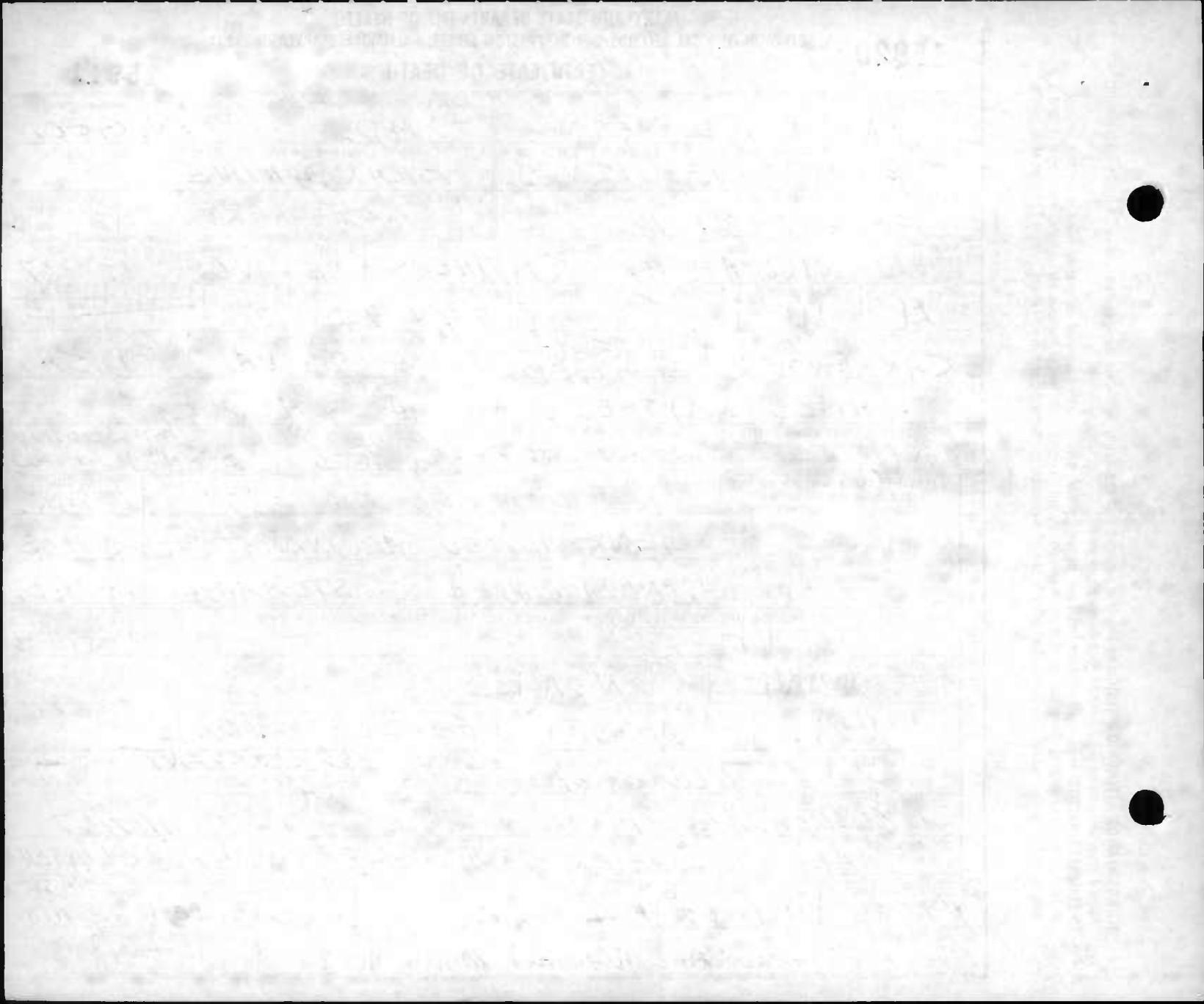
Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

15920 15911

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PR. GEO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BRANDYWINE</b>		c. LENGTH OF STAY IN lb <b>12 YRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 424 - RT. 1</b>		d. STREET ADDRESS <b>Box 424 - RT 1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First <b>WILLIAM A.</b> Middle <b>SMYTHERS</b>		4. DATE OF DEATH Month <b>NOV</b> Day <b>17</b> Year <b>1967</b>	
S. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>MAY 1, 1900</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPLOYED.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CARROLL CO. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES SMYTHERS</b>		14. MOTHER'S MAIDEN NAME <b>ELIA CAUDLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>228-09-2816-4</b>	
17. INFORMANT <b>MRS. BETTY SMYTHERS</b>		Address <b>RT 1 BOX 424 BRANDYWINE, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) <b>GENERALIZED CARCINOMATOSIS</b> DUE TO lost. } (c) <b>ADENOCARCINOMA OF STOMACH</b> DUE TO			
INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) <b>NONE</b>	
20c. TIME OF INJURY Month Day Year Hour a.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> At <input type="checkbox"/> of work <b>NONE</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>NONE</b>
20f. (City or town) <b>NONE</b>		(County) <b>NONE</b>	
(State) <b>NONE</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>NOV 15 1967</b> , to <b>PRESENT</b> , that (I) ( ) last saw the deceased alive on <b>NOV 15 1967</b> , and that death occurred at <b>145 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Arthur Shaver Jr.</b>		22b. DATE SIGNED <b>11/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR. MD.</b>		22d. ADDRESS <b>8808 BRANCH AVE COLUMBIA MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-19-67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>FULL GOSPEL CEM.</b>		23d. LOCATION (City or Town) <b>CEDARVILLE, P.G. MD.</b>	
24. FUNERAL DIRECTOR <b>Hunt Funeral Home, WALDORF, MD.</b>		ADDRESS	
25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>NOV 21 1967</b>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

15912

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

Signed with permission of deceased's doctor

*Rog-*

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> PRINCE GEORGES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		d. STREET ADDRESS <b>9810 Glenview Dr</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. MARYLAND Hosp - Clinton, Md</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>VANGIE B. STANTON</b>		First	Middle	Lost	4. DATE OF DEATH <b>NOV 15 1967</b>
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-11-06</b>	9. AGE (In years lost birthday) <b>61 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ANACOSTIA, SL DC</b>	
13. FATHER'S NAME <b>JOHN L JONES</b>			14. MOTHER'S MAIDEN NAME <b>EMMA BRATER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>JACK STANTON (Husband) SAME</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>463X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO					
Acute Congestive Heart Failure 5 min. INTERVAL BETWEEN ONSET AND DEATH					
Acute Pulmonary Embolus. 10 min. massive					
Acute Thrombophlebitis of leg. 36 hrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic CV disease with congestive failure, compensated</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11</b> p.m. <b>11</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>None</b>	20f. (City or Town) <b>Clinton</b> (County) <b>Prince George's</b> (State) <b>MD</b>	
21. I certify that (I) (This hospital) attended the deceased from <b>10/29 1967</b> to <b>Present</b> , that (I) (we) last saw the deceased alive on <b>Nov 10 1967</b> and that death occurred at <b>1145 AM</b> from causes and on the date stated above.					
22a. SIGNATURE <i>Arthur Shaver Jr.</i>		22b. DATE SIGNED <b>11/15/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR. MD</b>		22d. ADDRESS <b>8808 BRANCH AVE. CLINTON MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-18-1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		ADDRESS <b>81 Simmons Bros. 1661-Good Hope Rd SE Wash DC</b>		25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Young</i>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15922

CERTIFICATE OF DEATH

15913

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Pro Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt, Md.</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8150 Lake Crest Drive</b>		d. STREET ADDRESS <b>8150 Lake Crest Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Eva</b>		First <i>M.</i>	Middle <i>STEVENS</i>
4. DATE OF DEATH <b>Nov. 15 1967</b>	Month Nov.	Doy 15	Year 1967
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <b>May 20, 1904</b>		9. AGE (In years lost birthday) <b>63 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Kinsey</b>		14. MOTHER'S MAIDEN NAME <b>Emily Kellett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>James Stevens Crofton, Md.</b>	
17. INFORMANT <b>James Stevens</b>		Address <b>Crofton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease with left ventricular aneurysm</b> DUE TO (c) <b>Previous myocardial infarctions</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>{ 3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>
21. I certify that (I) (this hospital) attended the deceased from <b>August 1964</b> , to <b>Nov 10, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 10 1967</b> , and that death occurred at <b>10:20 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Harold I. Passes</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>Nov 15 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>HAROLD I. PASSES.</b>		22d. ADDRESS <b>1919 Conn Ave NW Wash DC 20009</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/18/1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>ARLINGTON</b>
23d. LOCATION (City, Town) <b>Drexel Hill</b>		(County) (State) <b>Pa</b>	
24. FUNERAL DIRECTOR <b>Francis Harsh's Sons Hyattsville, Md.</b>		ADDRESS	25a. REC'D BY REGISTRAR DATE <b>NOV 20 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15923		15914				
1. PLACE OF DEATH a. COUNTY <i>Pike George's</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton, Md.</i>		c. LENGTH OF STAY IN lb <i>10 mos</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pine View Gardens Health Care Center</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>CHARLES EDWARD STEVENSON</b>		First <b>CHARLES</b>	Middle <b>EDWARD</b>			
4. DATE OF DEATH <b>11 4 1967</b>	Month <b>11</b>	Day <b>4</b>	Year <b>1967</b>			
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 2 1895</b>			
9. AGE (In years last birthday) <b>72 yrs.</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM WORKER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>ANNE ARUNDEL Co, Md.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	13. FATHER'S NAME <b>William Francis Stevenson</b>	14. MOTHER'S MAIDEN NAME <b>Mary Wade</b>	Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.	17. INFORMANT			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>Gardens Colon collapse Carcinomatous from Ca of Prostate Anemia, hypochromic</i>				
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>Clinton, MD</b>	20f. (City or town) <b>Clinton, MD</b>	(County) <b>Anne Arundel Co, MD</b>	(State) <b>MD</b>
21. I certify that (I) (this hospital) attended the deceased from <b>12-28 1966</b> , to <b>12-4 1967</b> that (I) (we) lost saw the deceased alive on <b>11-4 1967</b> , and that death occurred at <b>Clinton, MD</b> , from causes and on the date stated above.						
22a. SIGNATURE <b>Alfred R Lappin Jr</b>		M.D. <b>Alfred R. LAPPIN, Jr.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11-4-67</b>
22c. PHYSICIAN'S NAME (Type) <b>Alfred R. LAPPIN, Jr.</b>		22d. ADDRESS <b>Clinton, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-8-67</b>		23b. DATE THEREOF <b>11-8-67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Family</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodmoor Md</b>		
24a. FUNERAL DIRECTOR <b>Rollins 4339-Hunt Blk</b>		24b. ADDRESS <b>11-8-67</b>	25a. REC'D BY REGISTRAR <b>NOV 7 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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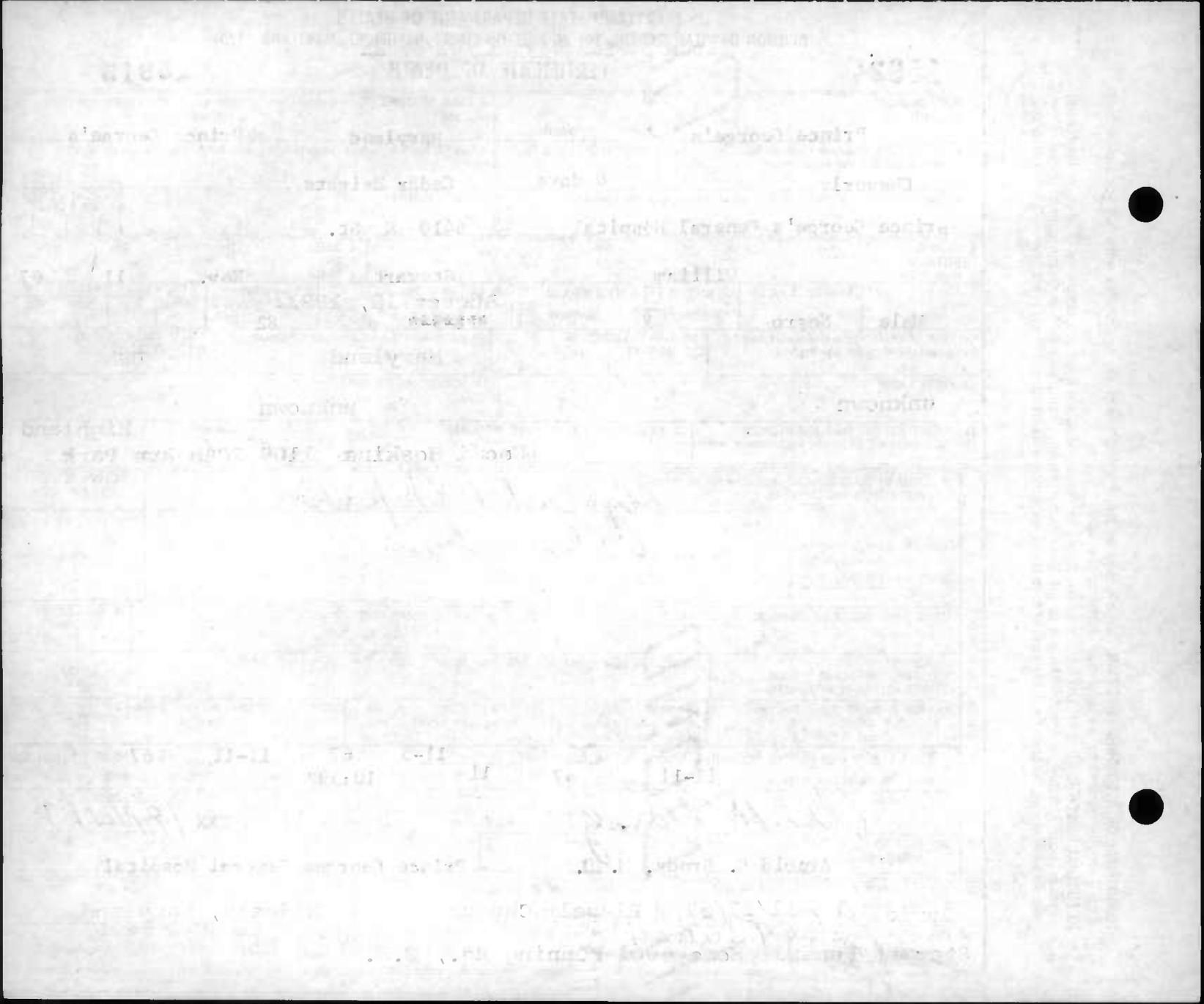
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>CERTIFICATE OF DEATH</b>													
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN lb <b>6 days</b>			d. STREET ADDRESS <b>6410 K St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>prince George's General Hospital</b>													
3. NAME OF DECEASED (Type or print)		First <b>William</b>	Middle	Last	4. DATE OF DEATH <b>Nov. 11 1967</b>	Month	Day	Year	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.			
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18 1881</b> <b>*1881** 1885</b>	9. AGE (In years last birthday) <b>82 yrs.</b>								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>unknown</b>						14. MOTHER'S MAIDEN NAME <b>unknown</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address <b>Naomi Hoskins 1108 70th Ave Park Highland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						<i>Myocardial Infarction Arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>11-5</b> , 19 <b>67</b> , to <b>11-11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-11</b> , 19 <b>67</b> and that death occurred at <b>10:59 AM</b> , from causes and on the date stated above.													
22a. SIGNATURE <i>Arnold G. Brody</i>			M.D. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <b>XXX</b>			22b. DATE SIGNED <b>19 Nov 67</b>				
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M. D.</b>			22d. ADDRESS <b>Prince Georges General Hospital</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/17/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Ridgely Church</b>			23d. LOCATION (City or Town) (County) (State) <b>Ridgely, Maryland</b>						
24. FUNERAL DIRECTOR <i>John T. Stewart</i>		ADDRESS <b>Stewart Funeral Home 4001 Benning Rd.,</b>		25a. REG'D BY REGISTRAR <b>NOV 16 1967</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						
VR A15 (4) 25M 1/67													



## MARYLAND STATE DEPARTMENT OF HEALTH

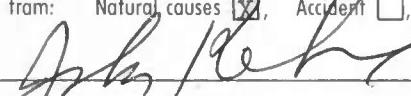
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

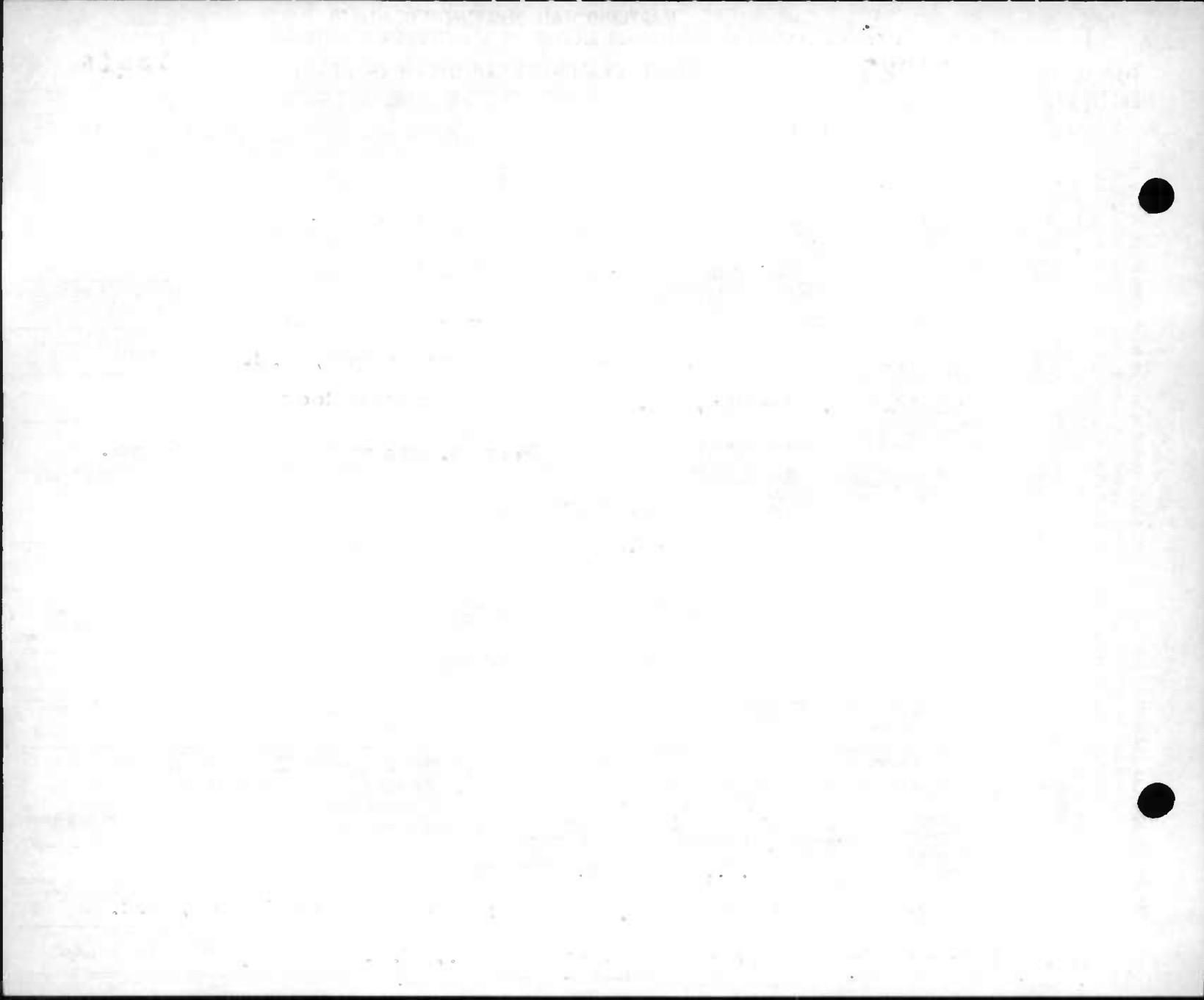
FOR STATE  
HEALTH DEPT.Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form  
5, may be retained for your files.TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of  
Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.VR A15ME (5)  
6M 1/66

15925

15916

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Holland Park</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>1107 69th Place</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>William Henry Stewart</b>		First	Middle	Lost	4. DATE OF DEATH <b>11 5 1967</b>	Month Year					
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11-28-07</b>	9. AGE (In years lost birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>William H. Stewart, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Bessie Cook</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address <b>Dora M. Stewart 1107 69th Ave.</b>		
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Arteriosclerotic Heart Disease</b> stating the underlying cause (c) <b> </b>										INTERVAL BETWEEN ONSET AND DEATH over 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11/11/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>				
24. FUNERAL DIRECTOR <b>John T. Stewart Jr.</b> Stewart Funeral Home			ADDRESS <b>4001 Benning Rd.,</b>		25a. REC'D BY REGISTRAR DATE <b>Nov 19 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

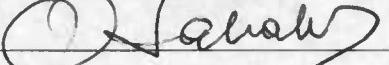


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15917

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>4 days/11 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Georges W. Sullivan, Sr.</b>		First	Middle
4. DATE OF DEATH <b>Nov. 12, 1967</b>	Last	Month	Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <b>xx</b> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-9-26</b>
9. AGE (In years lost birthday) yrs. <b>41</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington D C</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George Washington Sullivan</b>	14. MOTHER'S MAIDEN NAME <b>Eva Busey</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>WW II</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Grace Sullivan</b>	Address <b>Cheverly, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO <b>Arteriosclerosis &amp; Coronary Heart.</b> (c) <b>Coronary Insufficiency</b> .			
INTERVAL BETWEEN ONSET AND DEATH <b>3 day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>Colmar Manor</b> (County) <b>Pro Geo Md.</b> (State)
21. I certify that (I) <b>Channes</b> attended the deceased from <b>Nov. 12, 1967</b> , to <b>Nov. 12, 1967</b> , that (I) <b>xx</b> last saw the deceased alive on <b>Nov. 12, 1967</b> , and that death occurred at <b>2:50PM</b> , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>Nov. 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Channes Sahakyan, M. D.</b>		22d. ADDRESS <b>6001 Landover Road, Cheverly, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 16, 1967</b>	23c. NAME OF CEMETERY OR CEMATORIUM <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>		ADDRESS	25a. REC'D BY REGISTRAR
			25b. REGISTRAR'S SIGNATURE 



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15927

CERTIFICATE OF DEATH

15S18

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges Hospital</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville,</b> 182	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elsie Louise Swain</b>		First <b>Elsie</b>	Middle <b>Louise</b>
4. DATE OF DEATH <b>Nov 28, 1967</b>	Month <b>Nov</b>	Doy <b>28</b>	Year <b>1967</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 20, 1913</b>
9. AGE (In years lost birthday) <b>54 yrs.</b>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Doy <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Doy <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Levi Hill</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217 28 8428</b>	17. INFORMANT <b>Lake Swain</b> Address <b>Mechanicsville, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
DUE TO <b>5705</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>Shock</b> <b>18 hrs</b>			
DUE TO <b>lost</b>			
(c) <b>Intestinal obstruction</b> <b>5 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
MEDICAL CERTIFICATION Cholecystectomy "1/20/67" 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> , 1967, to <b>11/28</b> , 1967, that (I) (we) last saw the deceased alive on <b>11/28</b> , 1967, and that death occurred at <b>2:50 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John H. Bayley</b>		22b. DATE SIGNED <b>Nov 29, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN H. BAYLEY</b>		22d. ADDRESS <b>1835 EYE N.W., WASH DC, 20006</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 1, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Glenwood Cemetery</b>
23d. LOCATION (City or Town) <b>Washington D.C.</b>		(County) <b>DC</b>	(State) <b>DC</b>
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>DEC 5 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>

81282

1. Circumstances

1. When & how. Digital frame control cards

2. What is required.

3. How to get it. Option plates

4. Installation

5. Testing

FOR STATE  
HEALTH DEPT.

1  
M  
99  
2  
2  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

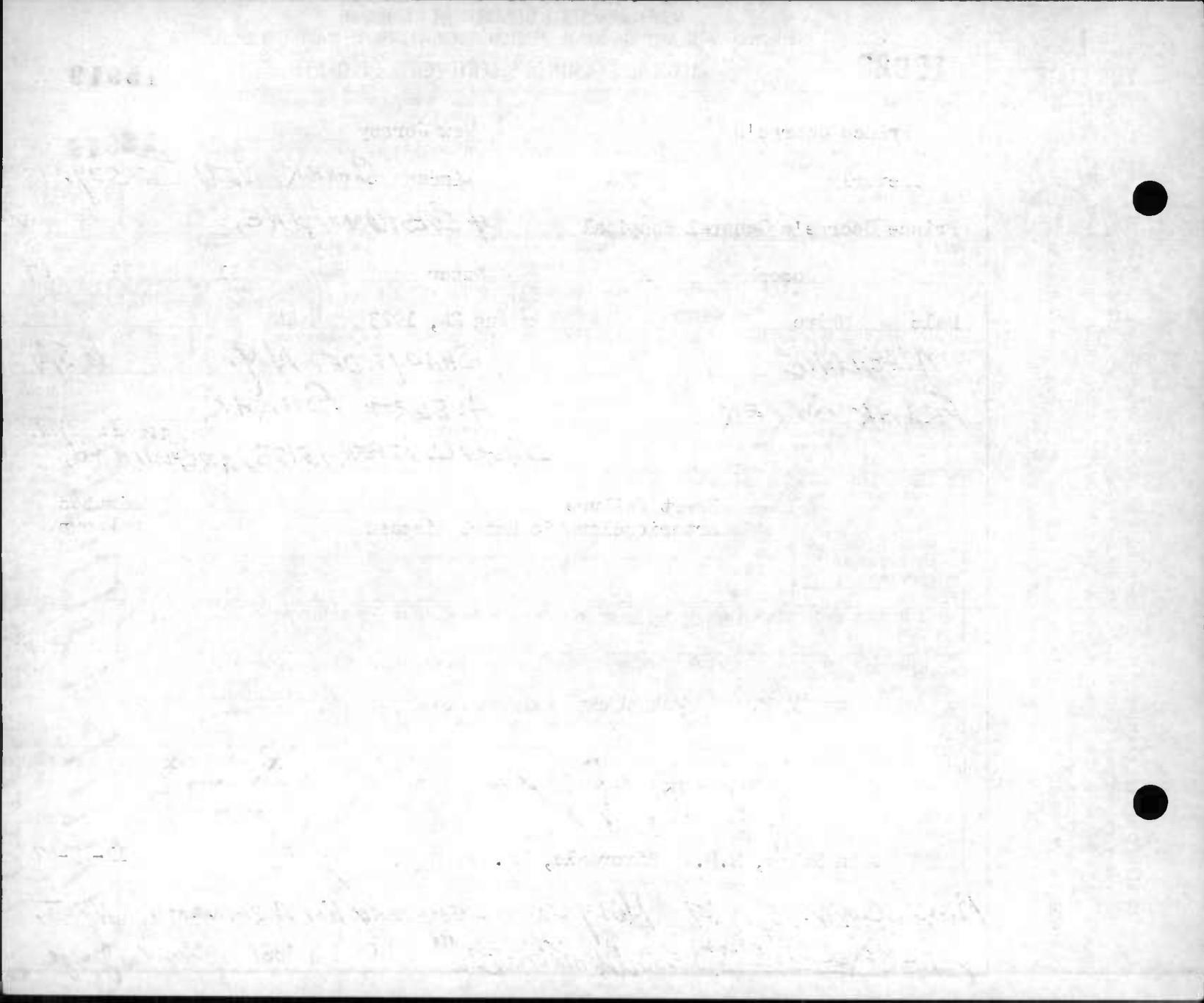
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15928

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15919

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linden</b> CLARK, NEW JERSEY-673		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>4 CRESTWOOD HANE,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Joseph Szper</b>		First <b>R</b>	Middle <b>Szper</b>	
4. DATE OF DEATH <b>11 11 1967</b>	Month <b>11</b>	Day <b>11</b>	Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug 24, 1923</b>	
9. AGE (In years lost birthday) <b>44 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <b>MECHANIC</b>	11. BIRTHPLACE (State or foreign country) <b>SHADYSIDE, N.Y.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK SZPER</b>	14. MOTHER'S MAIDEN NAME <b>ALBERTA BURAK-</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>JOSEPH C. SZPER 13123 LARCHDALE RD.</b>	17. INFORMANT <b>JOSEPH C. SZPER 13123 LARCHDALE RD.</b>	Address <b>LAUREL MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 4200 DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH minutes <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o.m. p.m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>John Kehoe</i> M.D. EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>				
22. DATE SIGNED <b>11-13-67</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>LAUREL MD</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Nov 15, 1967</b>	23b. DATE THEREOF <b>NOV 15 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>HOLY CROSS CEMETERY NO. ARINGTON, N.J.</b>	23d. LOCATION (City or Town) (County) (State) <b>ARINGTON, N.J.</b>	
24. FUNERAL DIRECTOR <i>J. Charles Judge</i>	25a. RECD BY REGISTRAR <b>NOV 15 1967</b>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		
VR A15ME (5) 6M 1/67				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21 film 397 2-16-68 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 21 Film 398 3-7-68 ams

15929

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15920

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>			d. STREET ADDRESS <b>9116 8th. Street</b>		
3. NAME OF DECEASED (Type or print)	First <b>Rozalia</b>	Middle <b>Szunyogh</b>	Last	4. DATE OF DEATH <b>11 29 1967</b>	Month Day Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7-21-1939</b>	9. AGE (In years last birthday) <b>28 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>			10b. KIND OF BUSINESS OR <b>Restaurant</b>	11. BIRTHPLACE (State or foreign country) <b>Hungary</b>	12. CITIZEN OF WHAT COUNTRY? <b>Hungary</b>
13. FATHER'S NAME <b>Jonas Hodvagner</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.	17. INFORMANT <b>Karoly Szunyogh Same as #2 (husband)</b>	Address
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide intoxication</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>Inhaled carbon monoxide while sitting in car</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>pm 11-29-1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. (City or town) <b>same as #2</b>	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>John Kehoe, M.D. Riverdale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	23d. LOCATION (City or Town) <b>Colmar Manor P.G. Md.</b>	(County) (State)
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>			ADDRESS	25a. REC'D BY REGISTRAR <b>DEC 5 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

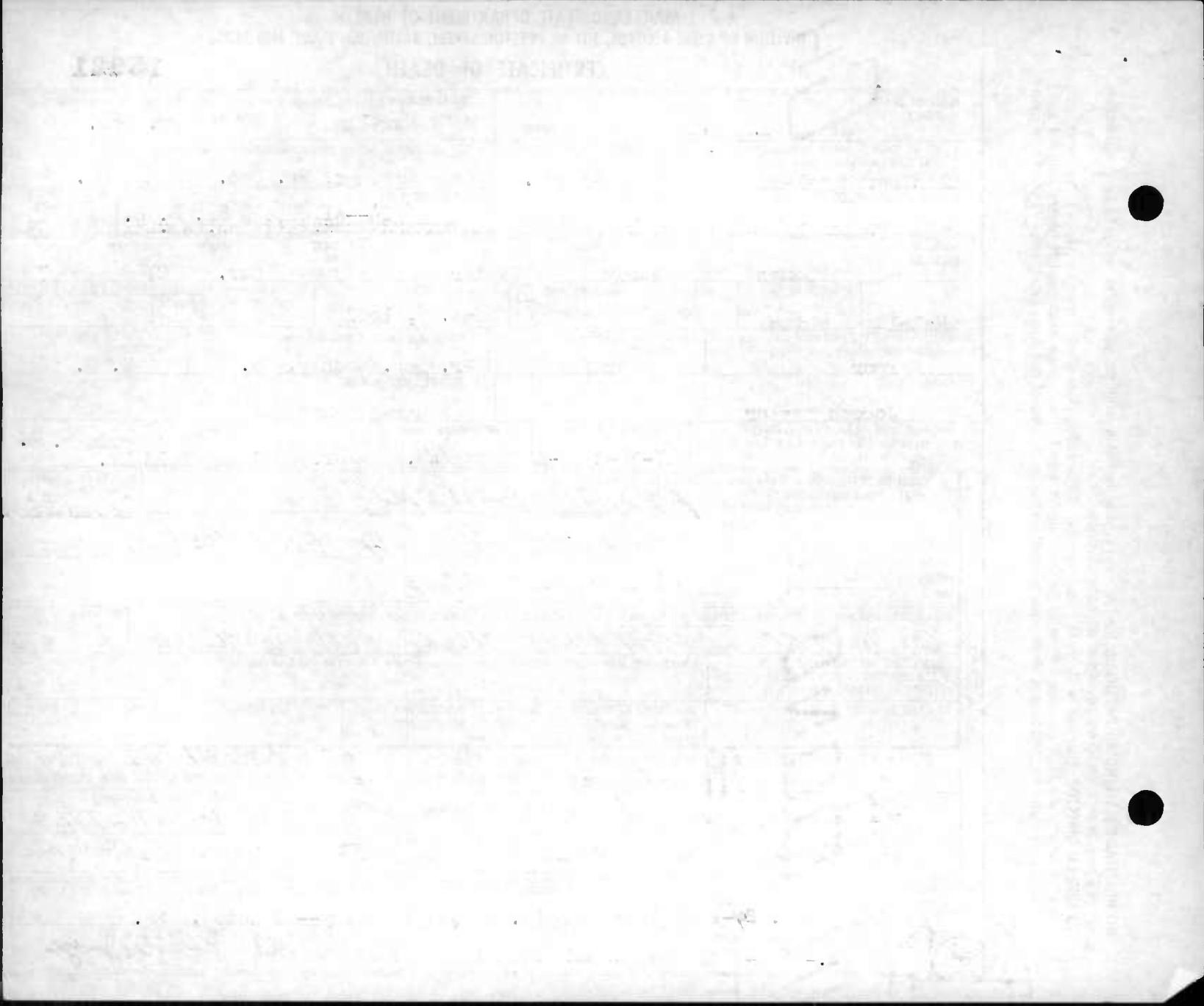
15921

**CERTIFICATE OF DEATH**

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Clinton, Maryland		85 yrs.		Camp Springs, Pr. Geo. County, Md. 16-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 6904 Allentown Rd. S. E. Washington D.C. XXXXXXXX				
75 Southern Maryland General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Thomas	Middle Moody	Lost Taylor	4. DATE OF DEATH Nov. 27 1967	Month Nov.	Day 27	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1882	9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Pr. Geo. County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Joseph Taylor				14. MOTHER'S MAIDEN NAME Sarah Young				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-8376-A		17. INFORMANT Thomas V. Taylor, 6931 Sheffield Dr. Camp Springs, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO PENAL FAILURE INTERVAL BETWEEN ONSET AND DEATH Stroke								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO GENERALIZED ASTERIOSIS X								
(c) DUE TO ADVANCED AGE								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) OLD TBC, ACTIVITY NOT PROVED, POSS. PENAL TBC								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Aug. 1967, to Nov. 27, 1967, that (I) (we) last saw the deceased alive on Nov. 27, 1967, and that death occurred at 4A M, from causes and on the date stated above.								
22a. SIGNATURE Robert W. Merkle, M.D.				22b. DATE SIGNED 11/27/67				
22c. PHYSICIAN'S NAME (Type) ROBERT W. MERKLE M.D.				22d. ADDRESS 50 N. MD. GEN. HOSP. CLINTON, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 27-1967		23c. NAME OF CEMETERY OR CREMATORIAL Christ Epis. Church Cemetery-- Clinton, Md.		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS Simmons Bros.-1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR NOV 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 1 25M 1/67				DATE				



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB BASE</b> c. LENGTH OF STAY IN lb <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GREENBELT</b> d. STREET ADDRESS <b>6110 BREEZEWOOD COURT</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MALCOLM GROW USAF HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> First <b>ALAN</b> Middle <b>TEITLER</b> (Type or print)		<b>4. DATE OF DEATH</b> Month <b>NOV</b> Doy <b>20</b> Year <b>1967</b>					
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 JAN 1941</b>	9. AGE (In years lost birthday) <b>26 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Doy <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USAF</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BROOKLYN, NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACK TEITLER</b>		14. MOTHER'S MAIDEN NAME <b>ROSLYN FINK</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>AUG67-Present 059-34-5727</b>		17. INFORMANT <b>WIFE</b>		Address <b>SAME AS #2</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPHYXIA</b> <b>241X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>STATUS ASTHMATICUS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Malcolm Grow USAF Hosp Andrews AFB Wash DC 20331</b>		20f. (City or town) (County) (State)	
21. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>19 Nov 1967</b> to <b>20 Nov 1967</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>20 Nov 1967</b> and that death occurred at <b>145 M</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>20 Nov 67</b>					
22c. PHYSICIAN'S NAME (Type) <b>JOHN F. LINDEMAN, CAPT, USAF</b>		M.D. ATTENDING MED. STAFF PHYS. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS. <input checked="" type="checkbox"/>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal Bur.</b>		23b. DATE THEREOF <b>11-21-67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Lebanon Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Queens, N.Y.</b>	
24. FUNERAL DIRECTOR <b>Falls Church Funeral Home</b> ADDRESS <b>1102 W. Broad St. Falls Church, Va.</b>		25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15923

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M 15931					
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY <i>Prince George</i>		a. STATE <i>MARYLAND</i>		b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bowie Clinton</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bowie</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pineview Gardens Health Care Center</i>		d. STREET ADDRESS <i>Fletcher Town Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY FRANCIS THOMAS</i>		First	Middle	Last	4. DATE OF DEATH Month Day Year <i>NOV 9 1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>March 2, 1875</i>	9. AGE (In years last birthday) <i>92 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>MARYland</i>	
13. FATHER'S NAME <i>Nathan Lawns</i>		14. MOTHER'S MAIDEN NAME <i>Unk.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO. <i>213-56-8009T</i>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>174X</i>		<i>Cerebrovascular collapse</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>to</i>		(b) <i>Carcinomatous due to</i>		<i>3 mos</i>	
		(c) <i>Carcinoma of rectum</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Clinton</i>	(County) (State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>8-7</i> , 19 <i>67</i> , to <i>11-9</i> , 19 <i>67</i> , that (I) (we) lost sow the deceased alive on <i>11-9</i> , 19 <i>67</i> , and that death occurred at <i>8:30A.M.</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>Alfred R. Loprin</i>		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> ME.O. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>11-9-67</i>		
22c. PHYSICIAN'S NAME (Type) <i>ALFRED R. LOPRIN</i>		22d. ADDRESS <i>CLINTON, MD.</i>			
23d. BURIAL, CREMATION, REMOVAL (Specify) <i>11-13-67</i>		23b. DATE THEREOF <i>11-13-67</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>St. John's Cemetery</i>	23d. LOCATION (City or Town) <i>Anne Arundel County</i>	(County) (State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>H-S Washington &amp; Son 4925 Dodge</i>		ADDRESS	25a. REC'D BY REGISTRAR <i>NOV 14 1967</i>	25b. REGISTRAR'S SIGNATURE <i>H. S. Washington</i>	

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REVIEW OF THE LITERATURE ON THE USE OF POLYMER

IN THE FIELD OF

1971

1971

REVIEW OF THE LITERATURE ON THE USE OF POLYMER

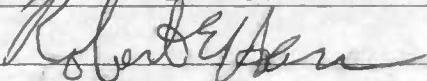
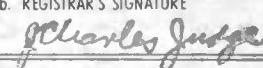
IN THE FIELD OF

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15924

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

<b>CERTIFICATE OF DEATH</b>				
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AFB BASE</b>		c. LENGTH OF STAY IN lb <b>18 Days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MALCOLM GROW USAF HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>NELLIE RYAN</b>		First <b>RYAN</b>	Middle <b>THOMPSON</b>	
4. DATE OF DEATH <b>NOV 14 1967</b>	Month Doy Year			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>17 Jul 1892</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NA</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>OURAY, COLO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>MICHAEL RYAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY HANNON</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NA</b>		
17. INFORMANT <b>HARRY J. THOMPSON (SON)</b>		Address <b>SAME AS #2</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>OVARIAN CARCINOMATOSIS</b> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Andrews AFB Wash DC 20331</b>	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>26 Oct 1967</b> , to <b>14 Nov 1967</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>14 Nov 1967</b> , and that death occurred at <b>0015 M</b> from causes and on the date stated above.				
22a. SIGNATURE 		22b. DATE SIGNED <b>14 Nov 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>ROBERT E. HARRIS, CAPT, USAF, MC</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11/18/67</b>		
23c. NAME OF CEMETERY OR CREMATORIUM <b>ROSE HILL BURIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FORT WORTH TEXAS</b>		
24. FUNERAL DIRECTOR <b>ROBERT E WILHELM FUNERAL HOME</b> <b>4308 SUITLAND ROAD, SUITLAND, MARYLAND</b>		25a. ADDRESS <b>4308 SUITLAND ROAD, SUITLAND, MARYLAND</b>		
25b. RECD BY REGISTRAR <b>NOV 20 1967</b>		25b. REGISTRAR'S SIGNATURE 		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

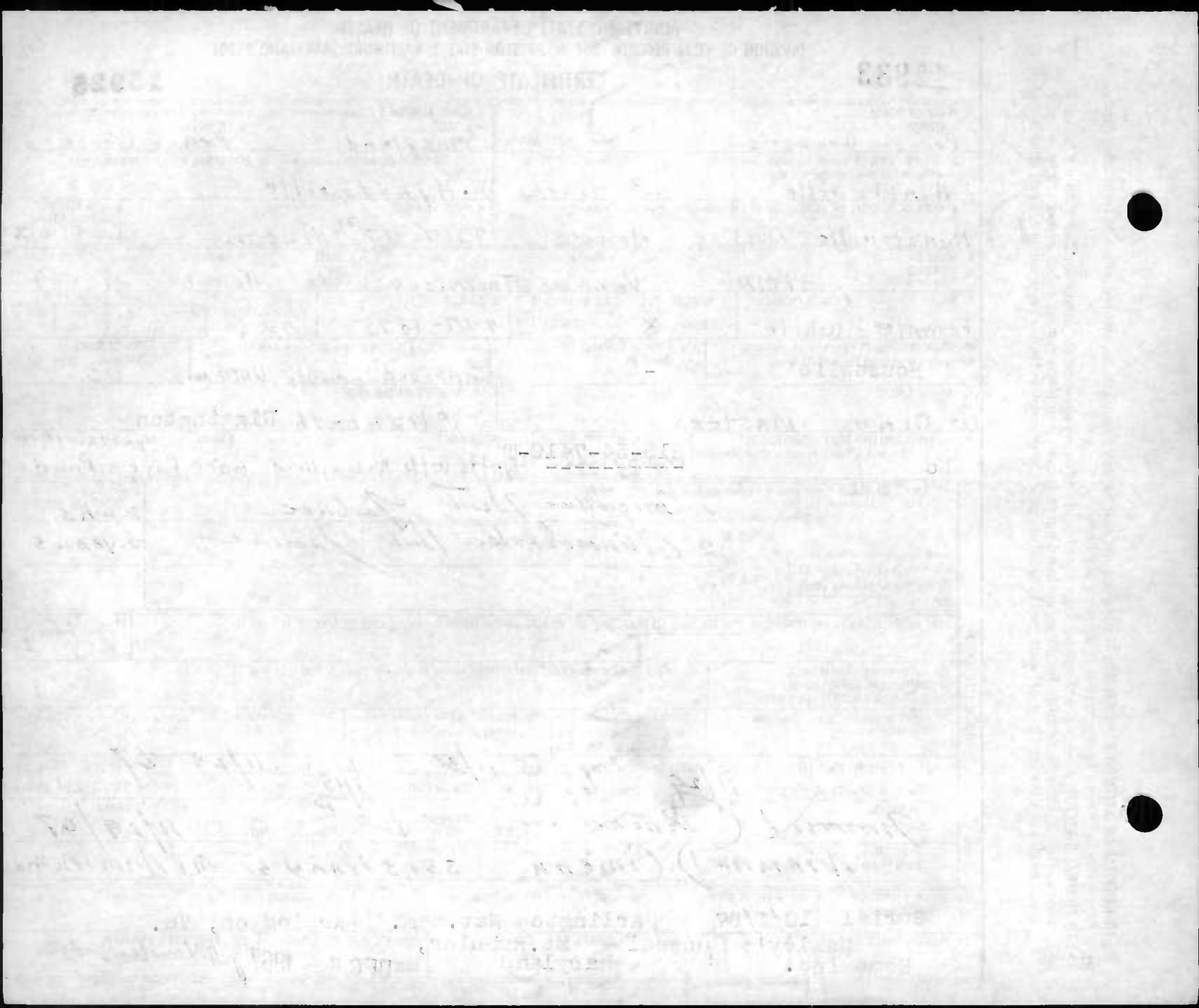
15933

CERTIFICATE OF DEATH

15925

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>3 Months</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Prince George's</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hyattsville Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W. Hyattsville</b>		d. STREET ADDRESS <b>7317 17<sup>th</sup> Avenue</b>				
3. NAME OF DECEASED (Type or print) <b>Alma</b>		First	Middle	Last	4. DATE OF DEATH Month <b>November</b>	Day <b>29</b>	Year <b>1967</b>			
S. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-17-1895</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Stafford County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>William Masters</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Wiggington</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-54-7419</b>		17. INFORMANT <b>Hyattsville Nursing Home</b>		Address <b>6500 Riggs Road</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b>		1. <b>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		2. <b>Cardiosclerosis that causes</b>		2 years						
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>11/30</b> , 19 <b>67</b> to <b>11/29</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>11/29</b> , 19 <b>67</b> , and that death occurred at <b>11/15</b> M, from causes and on the date stated above.										
22a. SIGNATURE <b>Norman J. Cimmeau</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/29/67</b>						
22c. PHYSICIAN'S NAME (Type) <b>Norman J. Cimmeau</b>		22d. ADDRESS <b>3503 Penny St Mt Rainier Md</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/4/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Nat.Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>				
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15934

15926

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> DOA		b. COUNTY <b>Harford</b>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>		d. STREET ADDRESS <b>Giles Lane Box 203</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Robert Albert Tildon</b>		First	Middle
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-17-1922</b> 1946
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		9. AGE (In years, last birthday) <b>79 20</b> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Havre de Grace, Md.</b>	
13. FATHER'S NAME <b>Morgan E. Tildon</b>		14. MOTHER'S MAIDEN NAME <b>Lucinda Snowden</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-48-9342</b>	17. INFORMANT Address <b>Morgan E Tilden Aberdeen, Maryland 21001</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> 8234 DUE TO <b>Trauma - auto accident</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant thrown from car after collision with tree.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>2:00 a.m. 11-16-1967</b>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Race Track Rd. &amp; old Chapel Rd. Bowie, Md.</b>
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>John Kehoe, M.D. Riverdale, Md.</b>	
22. DATE SIGNED <b>11-17-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>20 Nov 67</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Union M.E. Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Aberdeen, Maryland 21001</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 22 1967</b>	
24. FUNERAL DIRECTOR <i>Walter Wissner Jr.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
ADDRESS <b>Tarring Funeral Home Aberdeen, Maryland 21001</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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For 74

Information provided by  
John Dugay

*8*  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

*1*  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

15936 15528

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenbelt</i>		c. LENGTH OF STAY IN 1b <i>Since 4/1/66</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Greenbelt Convalescent Ctr.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William Edward Townsend</i>		First <i>W.</i>	Middle <i>E.</i>
4. DATE OF DEATH <i>November 10 1967</i>		Month <i>November</i>	Doy <i>10</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/29/1900</i>
9. AGE (In years lost birthday) <i>67 yrs.</i>		10. KIND OF BUSINESS OR INDUSTRY <i>Agent Purchasing Office U.S. Government</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Atlantic, N.J.</i>
12. CITIZEN OF WHAT COUNTRY <i>USA</i>		13. FATHER'S NAME <i>William H Townsend</i>	
14. MOTHER'S MAIDEN NAME <i>Louise Kreig</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>214-46-9422</i>		17. INFORMANT <i>William E. Townsend Same as #2 (Son)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO stating the underlying cause (c) DUE TO <i>Myocardial Infarction</i> Generalized Arteriosclerosis 3 minutes		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o). <i>Diabetes Mellitus, Hypercholesterolemia, Past History of CVA</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>1961</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) (State)	
21. I certify that (I) (This hospital) attended the deceased from <i>July 12, 1966</i> , to <i>Nov 10, 1967</i> , that (I) (We) last saw the deceased alive on <i>11-10 1967</i> , and that death occurred at <i>5:25 PM</i> , from causes and on the date stated above.		22b. DATE SIGNED <i>11/10/67</i>	
22a. SIGNATURE <i>Alan R. Gair</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>11/10/67</i>
22c. PHYSICIAN'S NAME (Type) <i>Alan R. Gair M.D.</i>		22d. ADDRESS <i>7227 Maple Ave, Takoma Park, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/14/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Ft. Lincoln</i>
23d. LOCATION (City or Town) <i>Colmar Manor P.G. Md.</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>Francis Gasch's Sons Hyattsville, Md.</i>		ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE NOV 13 1967



Item 18 Film 396 1-9-68 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15937

15929

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

If any delay is  
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to  
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with a  
5 may be retained for your files.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ernest</b>		First <b>A.</b>	Middle <b>Turner</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-7-11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13. FATHER'S NAME <b>George Turner</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>247-01-3239</b>	17. INFORMANT <b>Hospital Records</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>Arteriosclerotic heart disease</b> (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>2:15 pm p.m. 11-16 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> <b>Box 2316</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Upper Marlboro, P.G. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>11-18-67</b>	
ACTUAL SIGNATURE <b>John Kehoe</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>John Kehoe M.D., Riverdale, Maryland</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>NOV. 23-67 CAMP SPRINGS CEM. CEM. E. BERTON</b>		23b. DATE THEREOF <b>NOV. 23-67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>CAMP SPRINGS CEM. CEM. E. BERTON</b>
24. FUNERAL DIRECTOR <b>UNIVERSAL FUNERAL HOME</b>		ADDRESS <b>516 H St NE WASH DC</b>	23d. LOCATION (City or Town) (County) (State) <b>E. BERTON</b>
		25a. RECD. BY REGISTRAR <b>NOV 28 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17898

Items 13 & 14 taken from birth certificate  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>6 hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			d. STREET ADDRESS <b>3813 64th Ave.</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Baby</b>	Middle <b>Boy</b>	Last <b>Twynham</b>	4. DATE OF DEATH Month Day Year <b>Nov., 15 1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>14 Nov., 1967</b>	9. AGE (In years last birthday) yrs. <b>6</b>		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>P. G. Co. Maryland</b>			
13. FATHER'S NAME <b>Robert Alwyn Twynham</b>			14. MOTHER'S MAIDEN NAME <b>Carolyn Gail Finley</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>			16. SOCIAL SECURITY NO. <input type="checkbox"/>				
17. INFORMANT			Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>757X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO thorax, neck, right upper extremity. (c) DUE TO 3. Diffuse gliosis of cerebrum. 4 Respiratory distress syndrome						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <input type="checkbox"/> attended the deceased from <b>Nov. 14, 1967</b> , to <b>Nov. 15, 1967</b> , that (I) <input type="checkbox"/> last saw the deceased alive on <b>Nov. 15, 1967</b> , and that death occurred at <b>3:10 AM</b> from causes and on the date stated above.						22b. DATE SIGNED <b>11-15-67</b>	
22a. SIGNATURE <b>John W. Perkins</b>		M.D. ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-15-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John W. Perkins, M. D.</b>		22d. ADDRESS <b>6201 Riverdale Rd., Riverdale, Md.</b>					
23a. BURIAL, CREMATION, REMOVALS (Specify) <b>12-23-67</b>		23b. DATE THEREOF <b>12-23-67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Prince George's General Hosp. Cheverly, Maryland</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Charles W. Perkins, Jr. Adm.</b>			ADDRESS <b>Cheverly, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>
VR A15 (4) 25M 1/67		DATE					

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

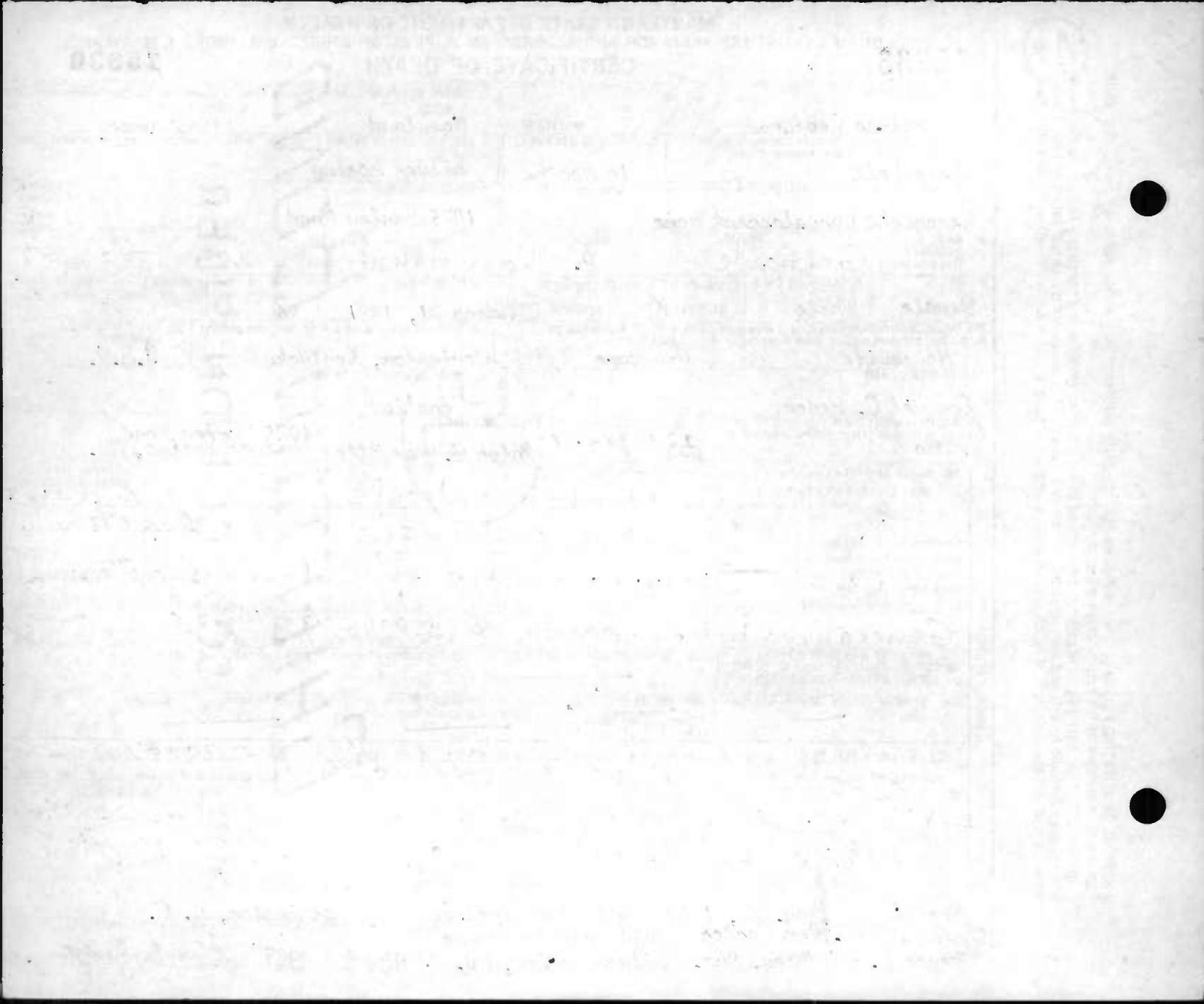
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

15938

**CERTIFICATE OF DEATH**

15930

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Greenbelt</i>		c. LENGTH OF STAY IN 1b <i>16 Months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>1025 Tanley Road</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greenbelt Convalescent Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Gertrude</i>	Middle <i>P.</i>	Last <i>Van Allen</i>	4. DATE OF DEATH Month <i>Nov</i> Day <i>20</i> Year <i>1967</i>	Month <i>Nov</i>	Day <i>20</i>	Year <i>1967</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 21, 1881</i>	9. AGE (In years last birthday) <i>86</i>	10. IF UNDER 1 YEAR Months <i>86</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Covington, Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Emanuel C. Peach</i>		14. MOTHER'S MAIDEN NAME <i>Cecelia</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>229-44-1401</i>	17. INFORMANT <i>Ralph C. Van Allen</i>	Address <i>1825 Tanley Road Silver Spring, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>332X</i> <i>6 days</i> DUE TO <i>Cerebro-sclerosis</i> DETERMINED Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diverticulitis of Colon</i> DETERMINED (c) <i>Generalized Arteriosclerosis</i> <i>Metabolic Arteriosclerosis</i> <i>Generalized</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arteriosclerosis</i> <i>Metabolic Arteriosclerosis</i> <i>Generalized</i>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Washington, D.C.</i>	(County) <i>District of Columbia</i>	(State) <i>D.C.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>May 1, 1965</i> to <i>Nov 20, 1967</i> , that (I) (we) last saw the deceased alive on <i>Nov 18, 1967</i> , and that death occurred at <i>Washington, D.C.</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>George L. Ball</i>		22b. DATE SIGNED <i>Nov 20, 1967</i>					
22c. PHYSICIAN'S NAME (Type) <i>George L. Ball</i>		22d. ADDRESS <i>10620 Georgia Ave Silver Spring, Md.</i>	ATTENDING M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Nov. 22, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Glenwood Cemetery</i>		23d. LOCATION (City, town or county) <i>Washington, D.C.</i>		
24. FUNERAL DIRECTOR <i>Glen Carter</i>		ADDRESS <i>8434 Georgia Avenue Warner E. Humphrey, Inc. Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR <i>NOV 24 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15939

15931

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>10 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>			d. STREET ADDRESS <b>3358 Chillum Rd.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Charles</b>	Middle <b>R.</b>	Last <b>Van Dolsen</b>	4. DATE OF DEATH Month <b>November</b> Day <b>24,</b> Year <b>19 67</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/21/96</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVERNMENT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>INDIANA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>ALBERT VAN DOLSEN</b>					
14. MOTHER'S MAIDEN NAME <b>SARAH DEVORE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>W.W.I</b>		17. INFORMANT <b>MRS ROSEMARY McLAUGHLIN</b> Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> DUE TO <b>LUBAR PNEUMONIA and</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CONGESTIVE HT FAILURE</b> (c) <b>ASHTO</b> <b>2 day</b> <b>year</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>JANES</b> (County) <b>COLMAR MANOR</b> (State) <b>MARYLAND</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 1967</b> to <b>NOV. 24, 1967</b> that (I) (we) last saw the deceased alive on <b>NOV. 24, 1967</b> and that death occurred at <b>9:30 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>John Kehoe</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <b>11-25-67</b>					
22c. PHYSICIAN'S NAME (Type) <b>John Kehoe M.D.</b> 22d. ADDRESS <b>RIVERDALE, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>Nov. 27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIALY <b>FORT LINCOLN</b>	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO</b>		ADDRESS <b>RIVERDALE, MARYLAND</b>		23d. LOCATION (City or Town) (County) (State) <b>COLMAR MANOR, MARYLAND</b>	
25a. RECD BY REGISTRAR DATE <b>NOV 27 1967</b>					
25b. REGISTRAR'S SIGNATURE <b>Charles J. Keane</b>					

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15932

15940

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4** may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's County Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eugene Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James</b>	First <b>James</b>	Middle <b>C.</b>	Last <b>Walsh</b>
4. DATE OF DEATH <b>11 12 1967</b>	Month <b>11</b>	Day <b>12</b>	Year <b>1967</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-4-96</b>
9. AGE (In years lost birthday) <b>71 yrs.</b>	10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS. <b>Days</b>	12. IF UNDER 24 HRS. <b>Hours</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DC Post Office</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Matthew N</b>		14. MOTHER'S MAIDEN NAME <b>Alice Gath</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> If yes give war or dates of service <b>yes WWI</b>		16. SOCIAL SECURITY NO. <b>577 10 3111</b>	
17. INFORMANT <b>Admitting Record</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4331 CONGENITIVE HEART FAILURE 2 WKS</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <b>ATRIAL FIBRILLATION UNKNOWN</b>			
DUE TO <b>(c)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 1962</b> , to <b>12 NOV 1967</b> , that (I) (we) last saw the deceased alive on <b>12 NOV 1967</b> , and that death occurred at <b>11 A.M.</b> , from causes and on the date stated above.			
22o. SIGNATURE <b>C.J. Hoomann</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12 - NOV. 67</b>
22c. PHYSICIAN'S NAME (Type) <b>C.J. Hoomann</b>		22d. ADDRESS <b>RIVERDALE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 16, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ft Lincoln Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Prop Geo Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR <b>NOV 17 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

Office Courses  
I. Office Courses  
II. Office Courses  
III. Office Courses  
IV. Office Courses  
V. Office Courses  
VI. Office Courses  
VII. Office Courses  
VIII. Office Courses  
IX. Office Courses  
X. Office Courses

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15941

## CERTIFICATE OF DEATH

15933

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**To FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN lb <b>5 yrs. 10 mo.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Home, 5805 Queens Chapel Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Julia</b>		First <b>B.</b>	Middle <b>Walsh</b>
4. DATE OF DEATH <b>November 19 1967</b>		Month	Day Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. AGE (In years last birthday) <b>82</b>		9. IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>New York City, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Charles Blum</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Dort</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>125-18-5644</b>	
17. INFORMANT <b>Mr. William J. Walsh 114 Eldrid Dr., S. S., Md.</b>		Address <b>Sacred Heart Home, Hyattsville, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS C MYOCARDIAL INFARCTION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b>		DUE TO <b>INFARTION</b>	
(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		DUE TO <b>6 YEARS</b>	
(c) <b>HYPERTENSIVE HEART DISEASE</b>		DUE TO <b>6 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> P.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Forest Glen</b> (County) <b>Maryland</b> (State) <b>21201</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>NOV 18 1967</b> , to <b>NOV 19, 1967</b> , that (I) (we) last saw the deceased alive on <b>NOV 18 1967</b> , and that death occurred at <b>11-19-67</b> M, fram causes and an the date stated above.			
22a. SIGNATURE <b>Thomas F. Collins</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>11-19-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS F. COLLINS</b>		22d. ADDRESS <b>322 - H 21 NE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St. John's Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Forest Glen, Maryland</b>		23e. ADDRESS <b>834 Georgia Ave</b>	
24. FUNERAL DIRECTOR <b>Thomas E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1967</b>	25b. REGISTRAR'S SIGNATURE <b>John Judge</b>
		DATE	

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1970

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

15942

15934

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Maryland</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxen Hill</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1405 Southen Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEONA S. WALSH</b>		First <b>S.</b>	Middle <b>L.</b>
4. DATE OF DEATH <b>Nov. 1, 1967</b>	Month <b>Nov.</b>	Day <b>1</b>	Year <b>1967</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 21, 1888</b>
9. AGE (In years (last birthday) yrs.) <b>79</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>AUGUST SCHWARZENTURB</b>		14. MOTHER'S MAIDEN NAME <b>Alva M. Bliss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>1577101988-577-4567</b>	17. INFORMANT <b>J. Baker Hebert</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Same</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Recent Cerebral vascular accident</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <b>67 11/11/67</b>
21. I certify that I attended the deceased from <b>1967 10/15</b> , 1967 to <b>1967 11/11</b> , 1967, that I last saw the deceased alive on <b>1967 10/15</b> , and that death occurred on <b>1967 11/11</b> P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <b>John J. O'Donovan M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 4, 1967</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Rock Creek</b>
22d. LOCATION (City, town, or county) <b>Wash D.C.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.L. O'Donnell 3603 1/2 St NW Wash DC</b>		24a. REC'D BY REGISTRAR <b>NOV 6 1967</b>	24b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>



1 15943

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

15935

**CERTIFICATE OF DEATH**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>24 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Fredeick</b>		First <b>W</b>	Middle <b>Wandschneider</b>	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>coal minor</b>		
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Hospital Records</b>		Address <b>Cheverly, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				
Interval between onset and death				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Baltimore</b> (County) <b>Md.</b> (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 29, 1967</b> , to <b>Nov. 21, 1967</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 21, 1967</b> , and that death occurred <b>12:55 AM</b> , from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE <i>Arnold G. Brody</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Nov. 22, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Arnold G. Brody, M. D.</b>		22d. ADDRESS <b>Prince Georges General Hospital</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 24, 1967</b>	23c. NAME OF CEMETERY OR X CEMETERY <b>Baltimore National</b>	23d. LOCATION (City or Town) <b>Baltimore</b> (County) <b>Md.</b> (State)
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>NOV 27 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

ACCEPTEES OF THE 1970 CENSUS AND HOUSEHOLD UNITS

NAME OF STATE OR TERRITORY

NUMBER OF HOUSEHOLDS

NUMBER OF HOUSEHOLD UNITS

NUMBER OF HOUSEHOLD UNITS IN WHICH THERE ARE NO CHILDREN

NUMBER OF HOUSEHOLD UNITS IN WHICH THERE ARE CHILDREN

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NUMBER OF HOUSEHOLD UNITS IN WHICH THERE ARE CHILDREN

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15944

15936

CERTIFICATE OF DEATH

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince George</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marbury</i>		d. STREET ADDRESS <i>OP 2</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pine View Gardens Health Care Center</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>Annie</i>	Middle <i>B</i>	Last <i>Warder</i>	4. DATE OF DEATH	Month <i>Nov</i>	Day <i>16</i>	Year <i>1967</i>	
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>10-7-88</i>	9. AGE (In years less birthday) yrs. <i>78</i>	IF UNDER 1 YEAR Months <i>-</i>	IF UNDER 24 HRS. Days <i>-</i>	Hours <i>-</i>	Min. <i>-</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Bowie</i>		14. MOTHER'S MARRIED NAME <i>JAMES A. BOWIE</i>		SUSANA WARD SIMMONS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-28-9328 DA-B</i>		17. INFORMANT <i>Mrs Margaret Grimes Box 4311 Upper Marlboro Md.</i>		Address <i>Lot 25 RFD</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>						INTERVAL BETWEEN ONSET AND DEATH		
493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO <i>PULMONARY EDEMA</i>						
{ stating the underlying cause last. (c)		DUE TO <i>PNEUMONIA</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Marbury</i>	(County) <i>Prince George</i>	(State) <i>Maryland</i>
21. I certify that (I) (this hospital) attended the deceased from <i>19</i> , to <i>19</i> , that (I) (we) last saw the deceased alive on <i>11/16 1967</i> , and that death occurred at <i>3:10 PM</i> , from causes and on the date stated above.								22b. DATE SIGNED <i>11/16/67</i>
22a. SIGNATURE <i>Suzanne Ladejinski</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>11/16/67</i>
22c. PHYSICIAN'S NAME (Type) <i></i>		22d. ADDRESS <i>11200 Lockwood Dr SILVERSPRING MD</i>						
23a. BURIAL, CREMATION, <i>Burial</i>	23b. DATE THEREOF <i>11/19/1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Park Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Marbury, Maryland</i>		(County) <i>Prince George</i>		(State) <i>Maryland</i>
24. FUNERAL DIRECTOR <i>Richard Funeral Home La Plata MD</i>	ADDRESS <i></i>	25a. REC'D BY REGISTRAR <i>NOV 21 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15045

15937

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY		PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b. 3 DAYS		a. STATE MARYLAND		
LAUREL				b. COUNTY MONTGOMERY		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Laurel General Hospital, Inc.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
3. NAME OF DECEASED (Type or print)		First FRANK	Middle L.	Last WEAVER	d. STREET ADDRESS	
4. DATE OF DEATH November 12 1967				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX Male Caucasian		6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 21 July 1891	9. AGE (In years last birthday) 76 yrs.	
8. IMMEDIATE CAUSE OF DEATH Arteriosclerosis		10. KIND OF BUSINESS OR INDUSTRY Civil Engineer		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Lloyd Everett Weaver		14. MOTHER'S MAIDEN NAME Mary Ella Ragan		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes. WW I		16. SOCIAL SECURITY NO. 378-16-8794		17. INFORMANT Wife Elizabeth D. Weaver Address Same as Item 2.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Arteriosclerosis		3 years				
260x Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Diabetes mellitus, adult-onset type		6 years				
DUE TO (c)						
DUE TO (b)						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED?				
Cirrhosis of liver; portal hypertension 7 years.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20e. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
19						
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.		22b. DATE SIGNED				
22e. SIGNATURE J. Richard Compton, MD		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		12 Nov 67
22c. PHYSICIAN'S NAME (Type)		M.D.		22d. ADDRESS		612 Main St., Laurel, Maryland 20810
23e. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 11-15-67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)
Burial		Arlington Natl Gem.		Arlington, Virginia		
24 FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D. BY REGISTRAR NOV 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

ZAPIN

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15947

CERTIFICATE OF DEATH

15938

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 from this certificate and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> 2 yrs. 10 M		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47.3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Manor 4922 LaSalle Road</b>		d. STREET ADDRESS <b>3225 Hiatt Place, N.W.</b>				
3. NAME OF DECEASED (Type or print) <b>Josephine</b> First <b>G.</b> Middle <b>Weber</b>		4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>1967</b>				
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>2/16/81</b>			
8. AGED (In years last birthday) <b>86</b> yrs.		9. IF UNDER 1 YEAR Months <b>9</b> Days <b>14</b> Hours <b>0</b> Min.				
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>				
13. FATHER'S NAME <b>Leonard Weber</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>XXXXXX579-60-1033</b>				
17. INFORMANT <b>Mrs. Clyde W. Hammerbacher-sister</b>		18. INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolus</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a) } stating the underlying cause lost. } (b) <b>Hypertensive Heart Disease</b> DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) <b>Attending Physician</b> attended the deceased from <b>April 29, 1965</b> , to <b>Nov. 30, 1967</b> , that (I) <b>last saw the deceased alive on Nov. 30 1967</b> , and that death occurred at <b>9 p.m.</b> , from causes and on the date stated above.						
22a. SIGNATURE <b>Thomas F Collins</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>Dec. 1, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>Thomas F Collins, M.D.</b>		22d. ADDRESS <b>322 H St. N.E. Washington, D.C. 20002</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/4/67</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Peter's</b>	23d. LOCATION (City or Town) (County) (State) <b>Harpers Ferry W. Va.</b>		
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		ADDRESS <b>1351 Rockville Pike</b>	RECD BY REGISTRAR <b>DEC 6 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

15946 17620

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>1 Mo., 2 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		RURAL-Upper Marlboro	
e. STREET ADDRESS <b>Gen. Delivery</b>		d. DATE OF DEATH <b>November 30, 1967</b>	
3. NAME OF DECEASED (Type or print) <b>John Henry Wedge</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Henry Wedge</b>		First <b>John</b>	Middle <b>Henry</b>
3. NAME OF DECEASED (Type or print) <b>John Henry Wedge</b>		Last <b>Wedge</b>	Month <b>November</b>
3. NAME OF DECEASED (Type or print) <b>John Henry Wedge</b>		Day <b>30</b>	Year <b>1967</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
5. SEX <b>Male</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1892</b>
5. SEX <b>Male</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. AGE (In years last birthday) <b>75 yrs.</b>
5. SEX <b>Male</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	10. IF UNDER 1 YEAR <b>Months</b>
5. SEX <b>Male</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	11. IF UNDER 24 HRS. <b>Days</b>
5. SEX <b>Male</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	12. Hours
5. SEX <b>Male</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	13. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gardening Work</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>John Ed. Wedge</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Jackson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Yes.</b>		16. SOCIAL SECURITY NO. <b>W.W.I.</b>	17. INFORMANT <b>Gen. Delivery</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Yes.</b>		16. SOCIAL SECURITY NO. <b>W.W.I.</b>	17. INFORMANT <b>Sarah H. Wedge - Upper Marlboro, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address <b>7402</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5501</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7402</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		DUE TO <b>Neuritis</b>	
} (c)		DUE TO <b>Shock &amp; peritonitis</b>	
		DUE TO <b>Reptured appendix</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Chronic degenerative disease</b>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9th</b>		20f. (City or town) (County) (State) <b>Upper Marlboro</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>9th</b> , 1967, to <b>30th</b> , 1967, that (I) (we) last saw the deceased alive on <b>30th</b> , 1967, and that death occurred at <b>31st</b> M, from the causes and on the date stated above.		22b. DATE SIGNED <b>11/30/67</b>	
22a. SIGNATURE <b>Robert B. Lasseter, M. D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Robert B. Lasseter, M. D.</b>		22d. ADDRESS <b>Upper Marlboro, Maryland 20870</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/67</b>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Mt. Carmel Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Upper Marlboro Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Upper Marlboro, Md. 20870</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 8 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

100% of the time, the first 1000 feet of the river is very rocky and turbulent. The water is clear and cold, with temperatures ranging from 50-60°F. The river flows through several small towns, including Gold Hill, Oregon, and Maryhill, Washington. The river eventually joins the Columbia River at Astoria, Oregon.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

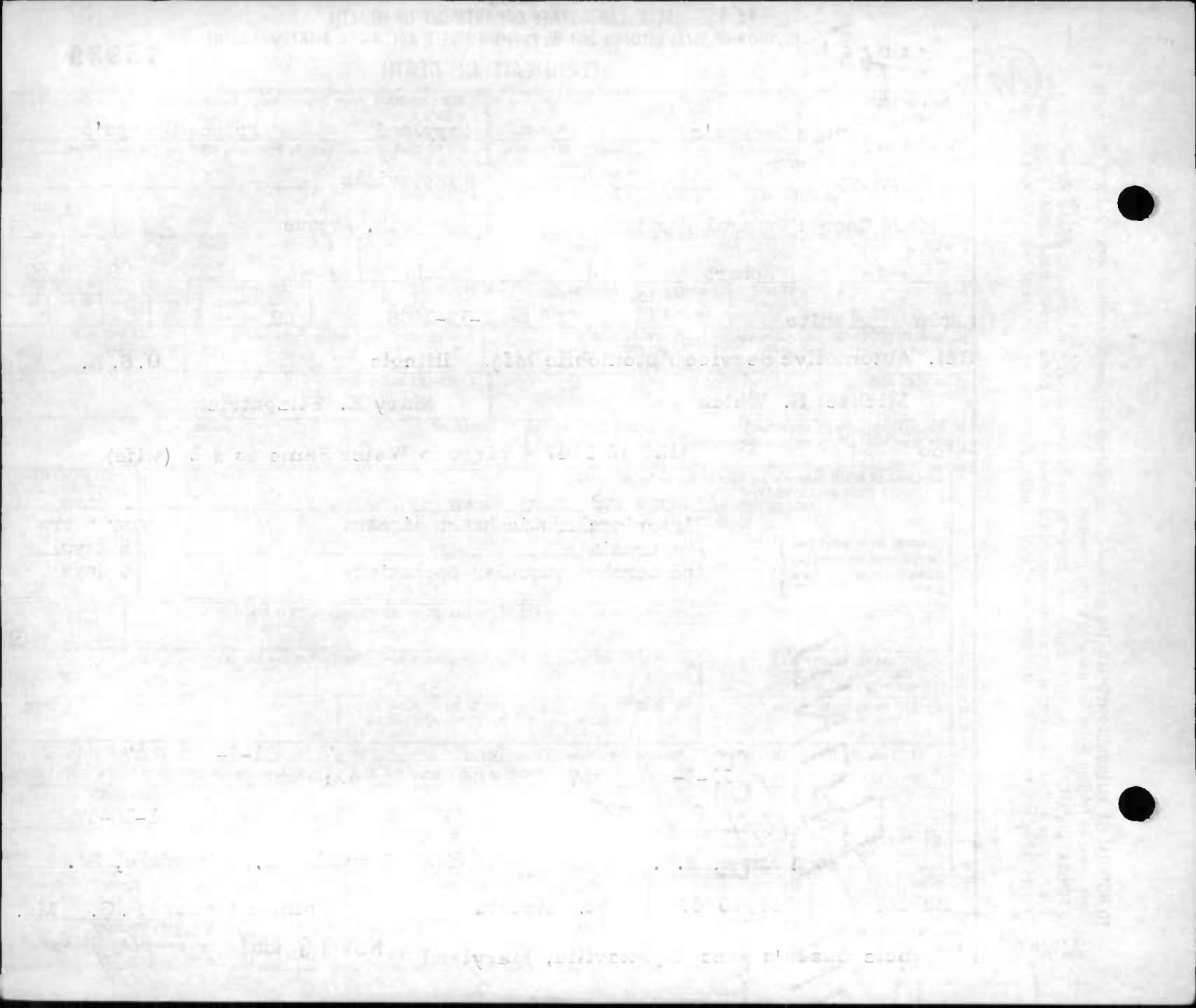
CERTIFICATE OF DEATH

15939

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		15948		2		15939		
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb <b>Cheverly</b> 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>3800 56th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>Robert</b>	Middle <b>J</b>	Last <b>Welch</b>	4. DATE OF DEATH 11 9 19 67	Month	Day	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1898</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Automotive Service Automobile Mfg.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile Mfg.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Michael H. Welch</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Fitzpatrick</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>121 12 5147</b>		17. INFORMANT <b>Virginia Welch Same as # 2 (wife)</b>		Address		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:          IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <i>4200</i>          DUE TO <b>Arteriosclerotic heart disease</b> over 5 yrs          Conditions, if any, which gave rise to immediate cause (a).          (b) <b>And uremia</b> 5 days          stating the underlying cause (c) <b>And Cerebro vascular occlusion</b> 5 days       </p>								
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p> <p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>								
<p>21. I certify that (I) (this hospital) attended the deceased from <b>June 19 57</b>, to <b>11-9-1967</b>, that (I) (we) last saw the deceased alive on <b>11-9-1967</b>, and that death occurred at <b>11:00 pm</b> from causes and on the date stated above.</p> <p>22o. SIGNATURE <i>John Kehoe</i></p>								
<p>M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>11-10-67</b></p> <p>22c. PHYSICIAN'S NAME (Type) <b>John Kehoe, M.D.</b> 22d. ADDRESS <b>6300 Riverdale Rd., Riverdale, Md.</b></p>								
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/13/67</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>		
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 13 1967</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE  
HEALTH DEPT.

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

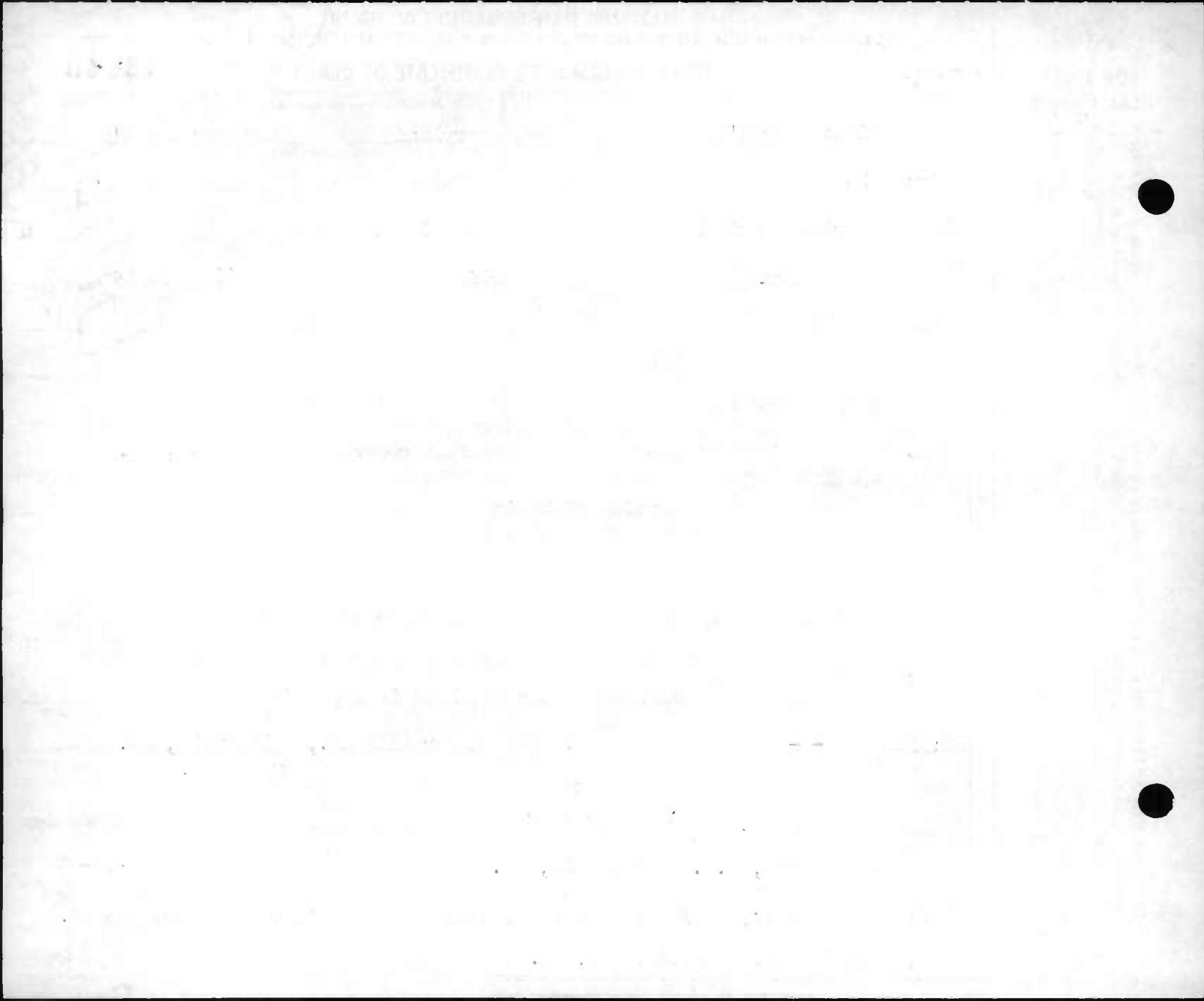
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15940

1. PLACE OF DEATH a. COUNTY <b>Prince George's Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Linda</b>		First <b>Werking</b>	Middle <b></b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>14 May 1953</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	9. AGE (In years last birthday) <b>14 yrs.</b>
13. FATHER'S NAME <b>Philip N Werking</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Hospital records</b>
Address <b>Riverdale, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO <b>Trauma auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in car involved in collision</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12:55 a.m. 11-5-1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4900 Powder Mill Rd., Beltsville, Md.</b>
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>11-15-67</b>
EXAMINER'S NAME (Type) <b>John Kehoe, M.D.</b>	M.D.		Address (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>
24. FUNERAL DIRECTOR <b>F, Gasch's Sons</b>	ADDRESS <b>Hyattsville, Md.</b>	25a. REC'D. BY REGISTRAR DATE <b>NOV 17 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15941

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN lb <b>5hrs.50mins</b>	b. COUNTY <b>Prince Georges</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>9513 Worrell Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Frank</b>	Middle -	Last <b>Whedbee</b>
4. DATE OF DEATH	Month <b>Nov.</b>	Day <b>28,</b>	Year <b>19 67</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/06</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	9. AGE (In years last birthday) <b>61 yrs.</b>
13. FATHER'S NAME <b>Samuel Whedbee</b>		14. MOTHER'S MAIDEN NAME <b>Annie Chauncey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>717 07 8558</b>	17. INFORMANT <b>Edith Whedbee</b>	Address <b>Lanham, Md</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5810</b>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Ruptured Esophageal varices</b>			
DUE TO (c) <b>Cirrhosis of the Liver</b>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 28, 19 67</b> , to <b>Nov. 28, 19 67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 28, 19 67</b> , and that death occurred at <b>12:50</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert T. Kelley, M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> PM	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>Robert T. Kelley, M.D.</b>		22d. ADDRESS <b>1302 18th St., NW, Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/1/67</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft. Lincoln Cemetery</b>
23d. LOCATION (City or Town) <b>Colmar Manor, P.G. Md.</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Maryland</b>		ADDRESS	25a. REC'D BY REGISTRAR DATE <b>DEC 5 1967</b>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

Lesson 4

How to handle

Personal notes

Notes

Personal notes

Personal notes

Notes

Personal notes

Personal notes

Notes

Personal notes

How to handle

How to handle

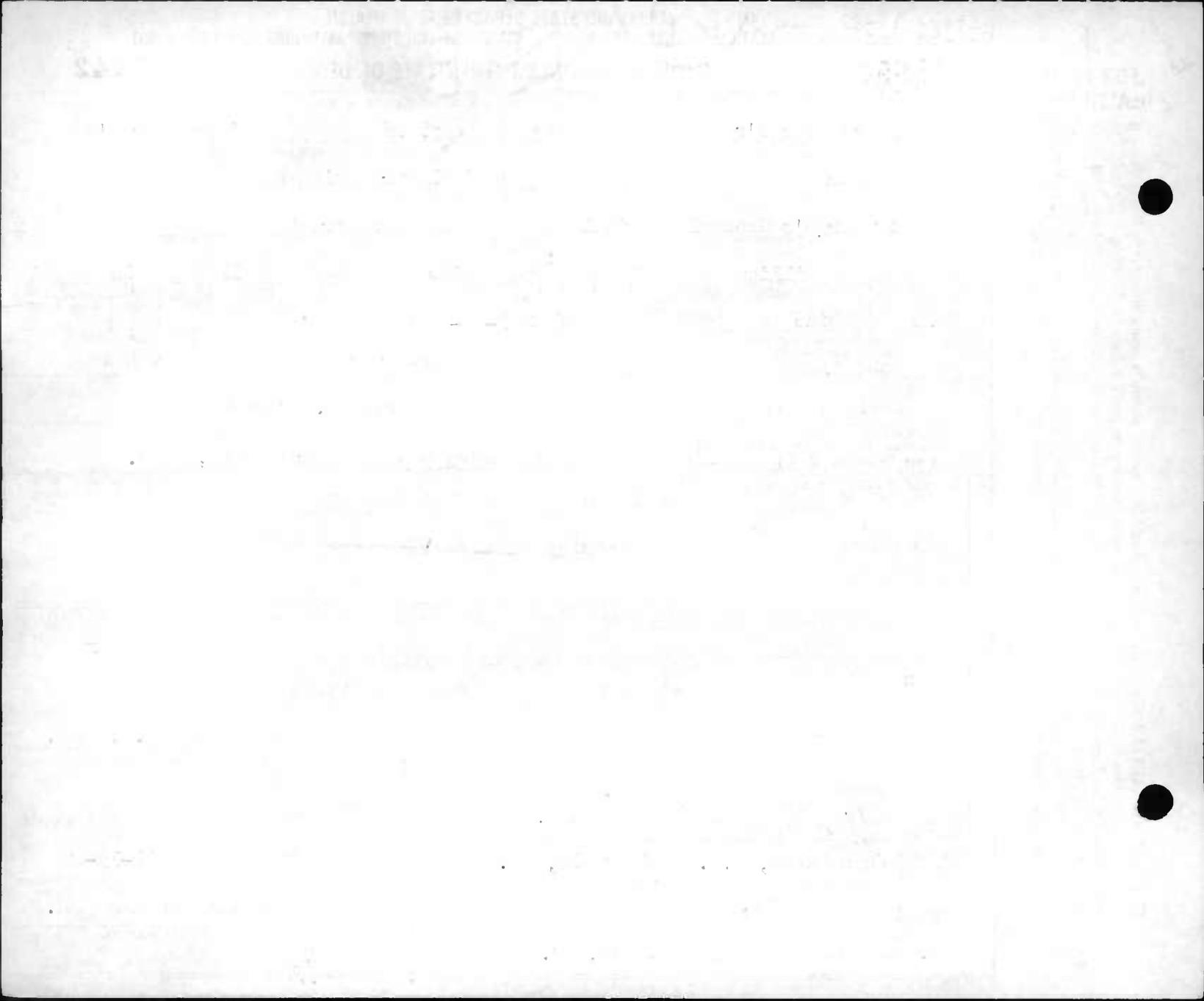
Notes

FOR STATE  
HEALTH DEPT.

1  
necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

16  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												15942			
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>Maryland</b>						a. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>DOA</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boulevard Heights</b>			d. STREET ADDRESS <b>5102 Byers Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>						d. DATE OF DEATH <b>11</b>						Month	Day	Year	
3. NAME OF DECEASED (Type or print)		First <b>William</b>	Middle <b>Ira</b>	Last <b>White</b>	4. DATE OF DEATH <b>11</b>		14	19	67						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-16-1922</b>			9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>			11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Lewis G White</b>						14. MOTHER'S MAIDEN NAME <b>Martha N. Mulchi</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> W W 11				16. SOCIAL SECURITY NO. <b>577 26 3419</b>		17. INFORMANT <b>Shirley M Hall</b>		Address <b>Oxen Hill, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Compression of anterior neck</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell thru kitchen wall partition and injured neck</b>											
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>noon</b> 11-14 1967				20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Boulevard Hgts P.G. Md.</b>		(County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>John Kehoe</i> M.D.			
EXAMINER'S NAME (Type) <b>John Kehoe, M.D. Riverdale, Md.</b>												ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Colmar Manor Pro Geo Md.</b>		22. DATE SIGNED <b>11-15-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 17, 1967</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) <b>Colmar Manor Pro Geo</b>		(County) (State)							
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>						ADDRESS		25a. REC'D BY REGISTRAR DATE <b>NOV 20 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												15943	
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <i>Prince George County</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>							
c. LENGTH OF STAY IN lb						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxon Hill</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pine View Gardens Health Care Center</i>						d. STREET ADDRESS <i>5527 OXON HILL RD.</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Joseph</i>	Middle <i>ALVIN</i>	Lost <i>Williams</i>	4. DATE OF DEATH <i>Oct. 2 1876</i>	Month <i>9</i>	Doy <i>3</i>	Year <i>1867</i>					
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH <i>Oct. 2 1876</i>	9. AGE (In years last birthday) <i>98 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>					
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>US Government</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Charles County - Maryland</i>						12. CITIZEN OF WHAT COUNTRY? <i>US</i>		
13. FATHER'S NAME <i>UNKNOWN</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>578-34-6137A</i>	17. INFORMANT <i>LORRAINE YOW</i>	Address <i>OXON HILL, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i>												INTERVAL BETWEEN ONSET AND DEATH	
4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular disease</i> (c) <i>Senility</i>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Clinton</i>	(County) <i>MD</i>	(State) <i>MD</i>					
21. I certify that (I) (this hospital) attended the deceased from <i>8-9</i> , 19 <i>61</i> , to <i>11-3</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11-3 1967</i> , and that death occurred at <i>9:12 AM</i> , from causes and on the date stated above.												22b. DATE SIGNED <i>11-3-67</i>	
22a. SIGNATURE <i>Alfred R. Lapan m.d.</i>				M.D. <input type="checkbox"/>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) <i>ALFRED R. LAPIN, M.D.</i>				22d. ADDRESS <i>Clinton, MD.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>11/6/67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>CEDAR HILL CEMETERY</i>				23d. LOCATION (City or Town) <i>PRINCE GEORGES, MARYLAND</i>				(County) <i>PRINCE GEORGES</i>	(State) <i>MARYLAND</i>	
24. FUNERAL DIRECTOR <i>Robert E. Wilhelm Funeral Home</i> ADDRESS <i>4308 Suitland Road Suitland Maryland</i>						25a. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE				
DATE <i>NOV 7 1967</i>													

11. ~~all~~ ~~comily~~ ~~area~~ ~~area~~  
12. ~~at 815 ft~~ ~~stiff~~ ~~slope~~  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15944

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>1 Hr. 50 Mins.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>		d. STREET ADDRESS <b>3131 QueensChapel Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				d. DATE OF DEATH <b>November 8 1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Morris</b>		First	Middle	Last	Month	Doy	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 10, 1888</b>	9. AGE (In years lost birthday) <b>79 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Government</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-12-2257</b>		17. INFORMANT <b>Bernard Kipperman 2205 Reddie Drive, SiL Spg.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO <b>Disbelle Melba -</b> (c) DUE TO <b>Generalize Arteriosclerosis -</b>		<b>General Vascular Accident</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/1</b> , 1967, to <b>11/8</b> , 1967, that (I) (we) last saw the deceased alive on <b>11/8</b> 1967, and that death occurred at <b>5 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>George S. Banning Jr.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. George S. Banning, Jr.</b>		22d. ADDRESS <b>3408 Rhode Island Ave., Mt. Rainier, Md.</b>				22b. DATE SIGNED <b>11/9/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/10/67</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>National Capital Hebrew</b>		23d. LOCATION (City or Town) (County) (State) <b>Hillside</b> Md.	
24. FUNERAL DIRECTOR <b>Donald M. Stein</b>		ADDRESS <b>232 Carroll Wash. DC 20012</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
VR A15 (4) 25M 1/67				DATE <b>NOV 13 1967</b>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, pages 2 and 3, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

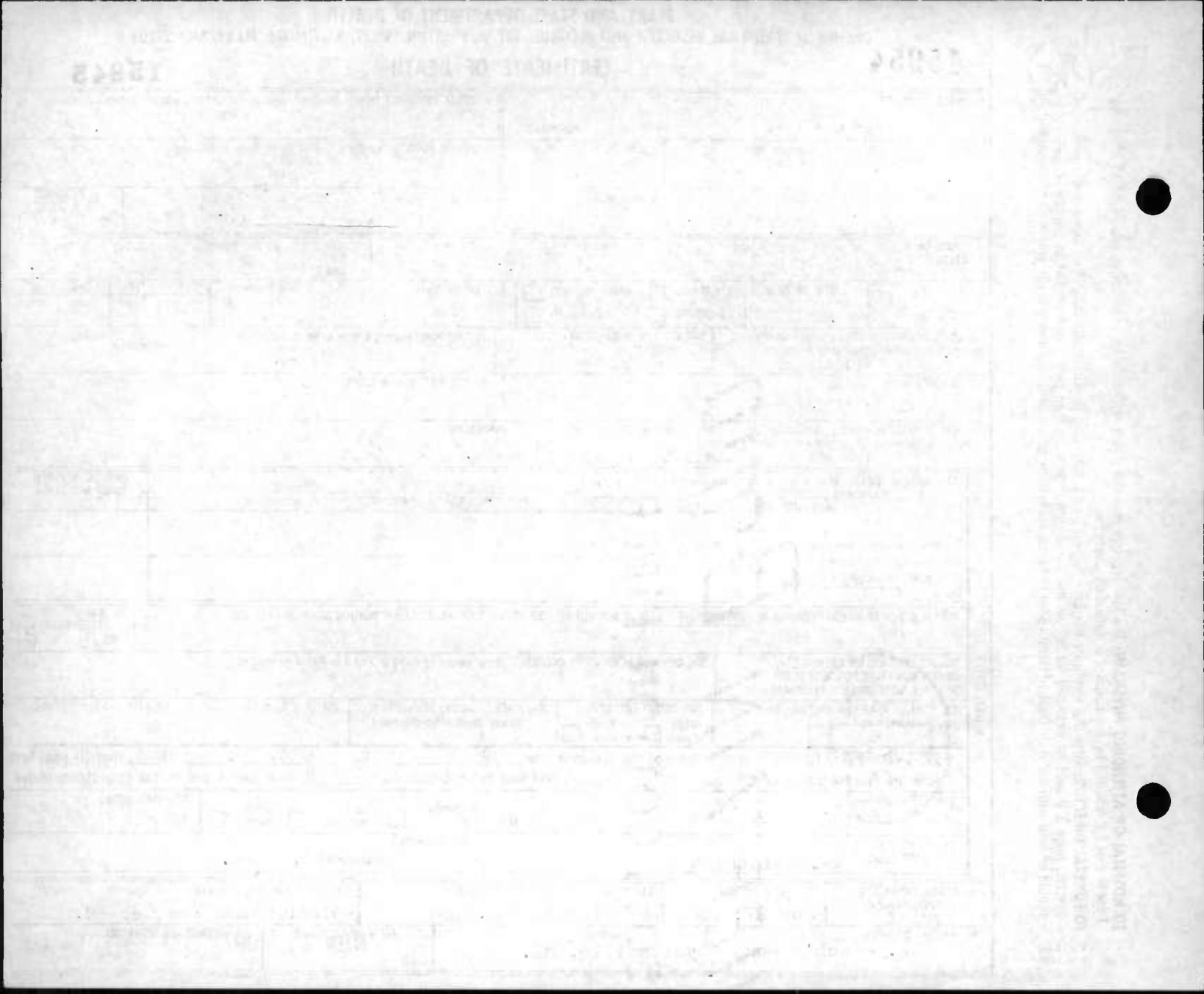
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15945

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENBELT		c. LENGTH OF STAY IN lb 22 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREENBELT CONVALESCENT CENTER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FRANKLIN		First	Middle K	Last WOODRUFF	4. DATE OF DEATH Nov 24 1967	Month Day Year
S. SEX M	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/87	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		IDb. KIND OF BUSINESS OR INDUSTRY OIL	11. BIRTHPLACE (County & State, or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME FRANKLIN A. WOODRUFF		14. MOTHER'S MAIDEN NAME LINDA POTTER		Address Linda Moffay College Park, Md		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 107-14-3263		17. INFORMANT		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.		Causes of Death Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 days		
(b) DUE TO		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 7, 1967 to Nov 24, 1967, that (I) (we) lost saw the deceased alive on Nov 24, 1967, and that death occurred at 522 M, fram causes and on the date stoted above.						
22a. SIGNATURE		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Nov 24, 1967			
22c. PHYSICIAN'S NAME (Type) Wm. Weintraub		22d. ADDRESS Greenbelt, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 27, 1967	23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR NOV 27 1967	25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 20 M 1/66		DATE				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15946

15955						
<p>1. PLACE OF DEATH            a. COUNTY  <b>Prince George's</b>            b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  <b>Cheverly</b></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)            a. STATE  <b>Maryland</b>            b. COUNTY  <b>Prince George's</b></p>				
<p>c. LENGTH OF STAY IN lb  <b>six hours</b></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  <b>Upper Marlboro</b></p>				
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  <b>Prince George's General Hospital</b></p>		<p>d. STREET ADDRESS  <b>Brooks Road</b></p>				
<p>3. NAME OF DECEASED (Type or print)</p>		<p>First <b>James</b></p>	<p>Middle <b>Daniel</b></p>	<p>4. DATE OF DEATH 11 17 19 67</p>	<p>Month Year</p>	
<p>5. SEX <b>male</b></p>	<p>6. COLOR OR RACE <b>Negro</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p>	<p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>5-10-14</b></p>	<p>9. AGE (In years last birthday) <b>53</b> yrs.</p>	<p>IF UNDER 1 YEAR Months Days Hours Min.</p>
<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <b>P. Geo. Co. Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>
<p>13. FATHER'S NAME <b>James Ernest Wright</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Mary E. Curtis</b></p>				
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/></p>		<p>16. SOCIAL SECURITY NO. <b>577-28-1069</b></p>		<p>17. INFORMANT <b>Elenora Wright</b></p>		<p>901-67 Ave. N.E. Washington, D.C.</p>
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>				
<p>PART I. DEATH WAS CAUSED BY: <b>332X</b></p>		<p>IMMEDIATE CAUSE (a) <b>Cerebro vascular occlusion</b></p>				
<p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p>		<p>DUE TO (b) <b>Cerebral Arteriosclerosis</b></p>				
<p>DUE TO (c)</p>						
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>				
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>				
<p>20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b></p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>						
<p>ACTUAL SIGNATURE <i>John Kehoe</i></p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Aquasco, Prince George's, Md.</b></p>				
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>23b. DATE THEREOF <b>11-20-67</b></p>	<p>23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Philips Ch. Cemetery</b></p>		<p>23d. LOCATION (City or Town) (County) (State)</p>	
<p>24. FUNERAL DIRECTOR</p>		<p>ADDRESS <b>Marcell Adams Aquasco, Md.</b></p>	<p>25a. RECEIVED BY REGISTRAR DATE <b>NOV 22 1967</b></p>		<p>25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i></p>	

containing too many problems

involving the following

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15956

CERTIFICATE OF DEATH

15947

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews</b>		c. LENGTH OF STAY IN lb <b>24 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Malcolm Grow USAF Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Mason Zeigler SR.</b>		First <b>William</b>	Middle <b>Mason</b>
4. DATE OF DEATH <b>Nov 30 1967</b>	Last <b>Zeigler</b>	Month <b>Nov</b>	Doy <b>30</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>MARCH 29, 1895</b>	9. AGE (In years lost birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paint</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Theodore Zeigler</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Sullivan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>322-07-9038</b>	
17. INFORMANT <b>William E. Zeigler Clinton, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>ASHD with Renal Failure</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>Clinton</b> (County) <b>Md.</b> (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7 Nov</b> , 1967, to <b>30 Nov</b> , 1967, that (I) (we) last saw the deceased alive on <b>30 Nov</b> , 1967, and that death occurred at <b>11:00 PM</b> causes and on the date stated above.		22b. DATE SIGNED <b>30 Nov 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RUBEN ALTMAN, CAPT USAF MC</b>		22d. ADDRESS <b>Malcolm Grow USAF Hosp Andrews AFB</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/4/1967</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>CEDAR HILL</b>
24. FUNERAL DIRECTOR <b>E.W. CHAMBERS CO. INC.</b>		25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

Quartier

Wohlfahrt

Grundbesitz

Reichsgraben

an der

Anhöhe

der Hauptstraße

Missionsschule UGAK

vor dem Schloss

Wittelsbach

Wittelsbach

zu

Wittelsbach

zu

der Kaiserin

Büste

Schloss

des Kaisers und Königs

Wittelsbach

zu den Kaisern

Wittelsbach

Wittelsbach

zu Volk 06 10 vol 7

MNHG 11

zu Volk 08

zu Volk 08 8

zu Volk 08 8

zu Volk 08 8

zu Volk 08 8